Human Growth & Development

A RESOURCE PACKET TO ASSIST SCHOOL DISTRICTS IN PROGRAM DEVELOPMENT, IMPLEMENTATION, AND ASSESSMENT

WISCONSIN DEPARTMENT
OF PUBLIC INSTRUCTION

Human Growth and Development: A resource packet to assist school districts in program development, implementation and assessment

4th Edition

Prepared by:
Narra Smith Cox, Ph.D.
University of Wisconsin - Madison
Department of Professional Development and Applied Studies

for the

Wisconsin Department of Public Instruction
Student Services/Prevention and Wellness Team

Supported by CDC Cooperative Agreement #U87/CCU522659-03

Wisconsin Department of Public Instruction
Elizabeth Burmaster, State Superintendent
Madison, Wisconsin

This publication is available from:
Student Services/Prevention and Wellness Team
Wisconsin Department of Public Instruction
125 South Webster Street
P.O. Box 7841
(608) 266-8960
(800) 441-4563
www.dpi.wi.gov/sspw/hgd.html

Bulletin #06058
January 2006

Acknowledgements

A special thanks to everyone who assisted in the development of this resource packet for human growth and development (HGD) education. It was through much collaboration and teamwork that this document reached completion. The University of Wisconsin - Madison Department of Professional Development and Applied Studies, the Department of Public Instruction Student Services/Prevention and Wellness Team, and Career and Technical Education Team provided support, guidance, and expertise, which helped to make this document a highly useful and effective technical assistance tool.

The following HGD workgroup members and other staff from the Department of Public Instruction were instrumental in the production of this document:

Linda Carey, Office Operations Associate
Jon Hisgen, Consultant, Health Education and Physical Activity
Emily Holder, Consultant, HIV/AIDS/STD Prevention Program
Narra Smith Cox, Assistant Professor, UW-Madison
Sharon Strom, Consultant, Family and Consumer Education
Brian Weaver, Consultant, Comprehensive School Health Programs

We appreciate the highly dedicated and talented Wisconsin teachers, administrators, and pupil services staff and national youth serving organizations who took the time to share with us their HGD education resources.

Disclaimer

This publication was supported by CDC Cooperative Agreement #U87/CCU522659-03. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of CDC. Inclusion of an external program, resource, or web site does not imply endorsement by or represent the view of the Wisconsin Department of Public Instruction (DPI). As a recipient of federal funding from CDC, DPI must abide by the Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments and Educational Sessions in Centers for Disease Control Assistance Programs (revised June 15, 1992, 57 Federal Register 26742).

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ACRONYMS used in this Resource Packet

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
CESA	Cooperative Educational Service Agency
DHFS	Wisconsin Department of Health and Family Services
DPI	Wisconsin Department of Public Instruction
FCE	Family and Consumer Education
GLSEN	Gay, Lesbian and Straight Education Network
HGD	Human Growth and Development
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bisexual and Transgender
SIECUS	Sexuality Information and Education Council of the United States
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
YRBS	Youth Risk Behavior Survey

1.0 BACKGROUND

PURPOSE OF THE RESOURCE PACKET

Sexuality, and expression of one's sexuality, is an important part of each person's identity. Achieving healthy sexuality and learning about this aspect of ourselves begins at birth and continues throughout our lives. This important and multidimensional concept involves anatomy, physiology, and growth and development, including self-esteem, body image, self-care, communication, values, an understanding of satisfying and healthy relationships, decision-making, sexual intimacy, responsibilities of parenthood, and a host of other relevant topics. Although parents are the primary sexuality educators of their children, children also receive messages about various aspects of sexuality from many other sources, including family members, friends, peers, schools, media, faith communities, and other institutions. Schools can be important partners with parents to provide children and adolescents with accurate and developmentally-appropriate sexuality education or human growth and development (HGD) instruction. The purpose of school-based sexuality education is to support children in gaining a positive view of sexuality and providing them with developmentally-appropriate knowledge and skills to make decisions now and in the future (National Sexuality Guidelines Task Force, 1991). Ideally, this instruction will enhance communication between parents or guardians and their children about this important topic.

The purpose of this ***Human Growth and Development Resource Packet*** is to provide school districts with information and resources to develop effective human growth and development programs in their schools that reflect the values and norms of the local community. This edition builds on the success of earlier editions and provides updated and new materials. It contains information and resources to help teachers, curriculum coordinators, administrators, and HGD advisory committee members:

- Identify desired objectives, goals, and outcomes for a district's HGD program;
- Evaluate existing or new curricula based on criteria of effective curricula;
- Plan for implementation of a HGD curriculum; and
- Educate others about the need, rationale, and approach the district develops to provide HGD instruction for its students.

RATIONALE FOR HGD INSTRUCTION

There are many reasons Wisconsin schools decide to provide human growth and development instruction:

- **Statutory support**. Wisconsin Statute 118.019 encourages all school boards to provide students in grades Kindergarten to 12 with human growth and development instruction. The purpose is "to promote accurate and comprehensive knowledge in this area and responsible decision making and to support and enhance the efforts of parents to provide moral guidance to their children."

- **Public health plan.** *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* is the Wisconsin state health plan for the decade 2000-

2010. The reduction of high risk sexual behavior is one of eleven health priorities identified in the plan. More information on the state health plan can be obtained in Section 3 of this document and from the Department of Health and Family Services' web site at **http://dhfs.wisconsin.gov/statehealthplan/**.

- **Youth risk behaviors**. Data document an unacceptably high number of Wisconsin youth engage in sexual behavior resulting in negative health outcomes. For example, too many young people experience pregnancy and sexually transmitted infections. The negative health outcomes are particularly striking when U.S. youth, including Wisconsin youth, are compared to their European counterparts. Young people need accurate information, motivation, and skills to avoid or reduce risks and promote their emotional and physical health.

- **Academic standards**. Wisconsin's model academic standards, especially in health education and family and consumer education, provide guidance about what students should know and be able to do at certain points in time. Human growth and development curriculum and instruction can be used to prepare students to meet these standards.

- **Parents and students want it**. National surveys underscore parental support for school-based sexuality education. For example, a recent survey conducted by National Public Radio, the Henry J. Kaiser Family Foundation, and the Kennedy School of Government called *Sex Education in America* documented that parents overwhelmingly support sexuality education in middle and high schools (National Public Radio et al., p. 5). According to this study, parents who support sexuality education believe the class will be helpful to their children, is effective in helping teens avoid HIV/AIDS and other sexually transmitted diseases and pregnancy, helps young people make responsible decisions about sex, and makes it easier for parents to talk with their children about sexuality.

The education and guidance provided by parents, in combination with accurate and age-appropriate human growth and development provided in schools, are important factors to promote health and well-being of young people. Decisions about how and when a school provides HGD instruction to meet the needs of youth in the community should be made as part of the HGD program planning process involving parents, teachers, school administrators, students, health care professionals, members of the clergy and other residents of the school district.

APPROACHES TO SEXUALITY EDUCATION

Many parents, educators, health professionals, clergy, and others have discussed the *type* of sexuality education they believe should be provided in the schools. Almost everyone agrees that the goal of school-based HGD instruction is to provide young people with the knowledge and skills to promote their health and well-being as they mature into sexually healthy adults. The question is: What approach should be used to do this?

Comprehensive sexuality education refers to sexuality education on a range of topics that begins in kindergarten and continues through grade 12. It takes an approach much broader than preventing unplanned pregnancies and disease transmission. According to SIECUS (2001), "Comprehensive sexuality education has four main goals:

- To provide accurate information about human sexuality
- To provide an opportunity for young people to develop and understand their values, attitudes, and beliefs about sexuality
- To help young people develop relationships and interpersonal skills, and
- To help young people exercise responsibility regarding sexual relationships, including addressing abstinence, pressures to become prematurely involved in sexual intercourse, and the use of contraception and other sexual health measures."

The term **comprehensive sexuality education** also refers to HIV/AIDS, sexually transmitted infections (STI), and pregnancy prevention education that not only stresses abstinence, but also includes information on contraceptives and other ways to reduce risks of negative health outcomes. This approach is also called **abstinence-based**, or **abstinence-plus** education because it provides an abstinence message and it provides information about ways that youth who are sexually active can reduce their risks related to HIV/AIDS, STI, and unplanned pregnancy. Most of the commercially available abstinence-based curricula are designed for middle school and high school students.

Abstinence education, abstinence-only education, or abstinence-only-until-marriage education refers to sexuality education and HIV/AIDS, STI, and pregnancy prevention education that emphasizes abstinence from all sexual behaviors outside of marriage. Typically this approach does not include information about contraceptives other than their failure rates. Programs funded by the 1996 welfare reform law, Section 510 (b) of Title V of the Social Security Act (referred to as Title V Section 510 Abstinence Education Program) are required to adhere to an eight-point definition of abstinence education. According to the legislation, abstinence education refers to "an education or motivational program which:

> A) Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity
> B) Teach abstinence from sexual activity outside marriage as the expected standard for all school-age children

C) Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
D) Teach that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity
E) Teach that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects
F) Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society
G) Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances
H) Teach the importance of attaining self-sufficiency before engaging in sexual activity."

Recipients of these abstinence-only-until-marriage funds are not required to emphasize all eight points, but they are not permitted to contradict any of the points in information provided to young people. In addition, grant recipients are permitted to discuss contraception only in terms of failure rates.

STATUS OF HGD INSTRUCTION IN WISCONSIN SCHOOLS

At this time, it is not possible to accurately describe human growth and development or sexuality education that is occurring in K-12 classrooms in Wisconsin schools. The Department of Public Instruction (DPI) does not routinely collect data on curricula that are being used to teach human growth and development. As such, many questions remain about human growth and development instruction in Wisconsin schools. For example, what HGD curricula are most frequently used? To what extent are the curricula implemented as written? To what extent do students learn, develop skills, and reduce risk behaviors following HGD instruction?

The DPI does have a general picture of the health education topics, including sexuality education, that are taught in middle and high schools. Results from the 2004 Wisconsin School Health Profile, a survey of principals and lead health teachers supported by the Centers for Disease Control and Prevention (CDC), indicate that the vast majority of required health education courses in grades 6-12 include instruction on growth and development (94%), HIV (98%), human sexuality (94%), pregnancy prevention (90%), and STI prevention (95%) (Wisconsin DPI, 2005). With the exception of instruction about HIV, the survey does not provide information about the specific content, quantity, or quality of this instruction. With regard to HIV prevention, the survey found that all high school teachers taught abstinence as the most effective method to avoid HIV infection. The survey found that while the majority of schools address a number of topics as part of their HIV instruction, they are less likely to provide instruction on topics considered to be sensitive or controversial, including how to correctly use a condom. The 2004 School Health Profile report can be obtained from **www.dpi.wi.gov/sspw/shepindex.html**.

Funding provides another measure of support for sexuality education. In recent years there has been no funding earmarked for DPI or cooperative educational service agencies (CESAs) to provide technical support to school districts for HGD instruction. DPI has received federal funding from the CDC to provide technical assistance and consultation to school districts on HIV/STI prevention and school health programs and education. In contrast, abstinence education grants have become a significant part of the sexuality education landscape in Wisconsin. The Wisconsin Department of Health and Family Services coordinates the Wisconsin Abstinence Education Project (WAEP) and the Wisconsin Abstinence Initiative for Youth (WAIY) which are supported by federal abstinence funds and a state funding match. The mission of WAIY is to promote, support, and encourage sexual abstinence to adolescents less than 19 years of age, with the long term goal of getting minority teen birth rates to the current level of the white teen birth rate. Multiple strategies are designed to meet project goals, including providing statewide abstinence education programs and resources, and funding community based projects that serve teens at highest risk of causing or experiencing pregnancy. For more information, see **www.dhfs.wisconsin.gov/waiy**.

SCOPE OF HGD INSTRUCTION

This *Human Growth and Development Resource Packet* addresses sexuality, and sexuality education, as a complex and multi-dimensional topic. Sexuality education can include developmentally-appropriate discussion of human development, relationships, personal skills, sexual behavior, sexual health and the influences of society and culture. Each school district will decide which components of sexuality will be addressed as part of its HGD program. Some districts may decide to provide HGD as a distinct unit of instruction; others may decide to integrate it into Health, Family and Consumer Education, Developmental Guidance, Science, Social Studies, English, or other subjects.

School districts will also decide on the content and messages provided for each HGD topic taught. For example, some districts will decide that HGD instruction at the high school level provide accurate and reliable information regarding the various methods of contraceptives, including their advantages and limitations, especially in relation to prevention of pregnancy and transmission of STI. Provision of instruction about contraceptives has historically been a controversial issue within some local communities. Wisconsin Statute 118.019 makes it clear that this decision rests with the local school board, which must be advised by a broad school-community HGD advisory council.

School districts will also identify community partners to support the human growth and development program. The Wisconsin DPI supports local partnerships of parents, teachers, school administrators, students, health care professionals, members of the clergy and other community partners to address youth risk behaviors and provide mutually reinforcing prevention and health promotion messages for children and youth. Young people need to hear messages that refraining from sexual intercourse and alcohol and other drugs is the most effective prevention strategy to prevent unintended pregnancies, STIs, and HIV/AIDS. Local partnerships can help create a climate in schools and the community that supports young people who choose to abstain. Similarly, local

partnerships can provide education and resources to help young people reduce their risks if and when they do become sexually active.

HGD PROGRAM PLANNING

Developing and implementing a K-12 HGD curriculum, like any important program, requires careful planning to increase the likelihood that the program will achieve its desired outcomes. Program planning consists of a series of activities that collectively help educators design, develop, and deliver a program for the target audience. Key planning activities for developing a HGD program include:

- Involving key stakeholders (parents, teachers, school administrators, curriculum coordinators, students, health care professionals, members of the clergy, etc.) in the planning process.
- Identifying appropriate goals and objectives based on the current situation, assets, problem, or needs in the school and community.
- Determining the curriculum or program with the "best fit" or alternatively, developing a new program, replicating an existing program, tailoring a program for a new target population, or adapting a program for a new target population.
- Assuring that human and material resources are in place.
- Assuring that students are ready to participate in the program.
- Implementing the program.
- Evaluating the program.
- Revising the program for future implementation.

In Wis. Stat. 118.019 under the *advisory committee* heading it reads, "The advisory committee shall develop the human growth and development curriculum and advise the school board on the design, review and implementation of the advisory committee's human growth and development curriculum." "Develop" can be interpreted in the broad sense of ongoing development/evolution. If interpreted this way, the advisory committee does not necessarily write the curriculum (lessons), especially if the school district has a curriculum in place, which is the case for most districts. Feedback, edits, decisions on topics and timing are all effective ways for a committee to work and develop a curriculum. However, nothing in the law prevents the committee from actually writing and developing lessons or a curriculum, for that matter.

When developing a curriculum it is important to consider the background, skills and knowledge of those responsible for writing the curriculum. Usually the primary curriculum writers are the content specialists within the district, which would include teachers and curriculum coordinators who have formal professional preparation in curriculum, instruction, and student assessment. The level of involvement in the actual writing of new or revised lessons can vary greatly among advisory committees because the competency level of advisory committees can also vary greatly. In the end, the level of involvement is the school district's decision. For more information on HGD advisory committees see Section 4 of this document.

Increasingly, organizations are using logic models as part of the planning process. A logic model is a concise causal description showing the connections between perceived needs, available resources, program activities, and program goals. In terms of planning a HGD program, a logic model can help clarify the current situation and a district's rationale for the HGD program based on documented health indicators such as rates of teen pregnancy, STI, and self-reported high risk sexual behaviors. A logic model can also identify necessary resources to implement the program. In the case of HGD, important resources include statutory guidance, a local HGD Advisory Committee, and school staff members who will actually implement the HGD program or curriculum. The logic model also describes the important activities, such as communicating with parents, and of course, actually providing HGD instruction. And finally, a logic model encourages clarity about the short-term outcomes and longer-term goals or impacts of the HGD program. Specifically, the logic model encourages districts to articulate the knowledge, attitudes, and intentions expected from the HGD curriculum and instruction, and the desired longer-term impacts. In short, a logic model can articulate how a school or school district's HGD program contributes to the health of young people. See Resource 1.2: HGD Program Planning Logic Model for an example of a completed logic model.

Web-based Resources

For additional information on program planning and logic models, see The DPI Educator Resource Center for Youth Sexual Risk Behavior Prevention at **www.dpi.wi.gov/sspw/hivercindex.html**. This site is designed to serve staff from Wisconsin schools, community-based organizations, and government agencies, as well as others in Wisconsin who are working to prevent youth sexual risk-taking and related health consequences. In addition, the UW-Extension Program Development and Evaluation, **www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html**, and ETR's Resource Center for Adolescent Pregnancy Prevention, **www.etr.org/recapp/BDILOGICMODEL20030924.pdf**, have developed resources to assist with the development of logic models.

ORGANIZATION OF THE HGD RESOURCE PACKET

The HGD Resource Packet includes eight sections. Each section is designed to provide background information and resources for planning HGD programs. Most of the sections include numerous resources, including background information, worksheets, information handouts, and sources for additional information.

Section 1.0 Background
Section 2.0 State Statutes
Section 3.0 Profile of Wisconsin Youth
Section 4.0 HGD Advisory Committee
Section 5.0 Parental Communication
Section 6.0 Effective HGD Curriculum, Instruction and Assessment
Section 7.0 Professional Development for School Staff
Section 8.0 Resources

Your commitment to strengthening your school district's HGD instruction is important – not only as it contributes to the knowledge, skills, and attitudes of children and young people in the upcoming months, but also as it contributes to their health and wellness in the years ahead.

References:

National Public Radio, Henry J. Kaiser Family Foundation, and Kennedy School of Government. *Sex Education in America*. Washington, D.C. (2004).

SIECUS. Report Supplement. Issues and Answers: Fact Sheet on Sexuality Education. Volume 29, Number 6, p. 2 (August/September, 2001).

Wisconsin Department of Public Instruction. Wisconsin School Health Profile Report (2005). **www.dpi.wi.gov/sspw/shepindex.html**.

Resource 1.1

DPI Statement on K-12 HGD Instruction

Sexuality, and expression of one's sexuality, is an important part of each person's identity. Achieving healthy sexuality and learning about this aspect of ourselves begins at birth and continues throughout our lives. Infants receive important messages about human contact, interactions between individuals, and expressions of intimacy from their parents and other caregivers. Children continue to absorb messages about these and other aspects of sexuality and develop attitudes about themselves, including their bodies, long before they enter school. Attitudes and expectations about trusting relationships, worthiness of love, expression of respect and care for themselves and others, as well as other important ideas continue to develop through elementary, middle school, and high school years.

Sexuality is an important and multidimensional concept that includes anatomy, physiology, and growth and development, and also self-esteem, body image, self-care, communication, values, and an understanding of satisfying and healthy relationships, decision-making, sexual intimacy, responsibilities of parenthood, and a host of other topics. Although parents are the primary sexuality educators of their children, children also receive messages about various aspects of sexuality from myriad other sources, including other family members, friends, peers, schools, media, faith communities, and other people and institutions. Schools can be important partners with parents to provide children and adolescents with accurate and developmentally appropriate sexuality education or human growth and development (HGD) instruction. The purpose of school-based sexuality education is to support children in gaining a positive view of sexuality and providing them with developmentally appropriate information and skills to make decisions now and in the future (National Sexuality Guidelines Task Force, 1991). Ideally, this instruction will enhance communication between parents/guardians and their children about this important topic.

In conclusion, the education and guidance provided by parents, in combination with accurate, age- and developmentally-appropriate HGD instruction provided in schools, are important factors to promote the health and well-being of young people. Decisions about how and when a school provides HGD instruction to meet the needs of youth in the community need to be made as part of the school district's HGD Advisory Council's program planning process involving parents, teachers, school administrators, students, health care professionals, members of the clergy and other residents of the school district.

Resource 1.2 Human Growth and Development Program Planning Logic Model

Current Situation	**Resources**	**Activities**	**Short-term Outcomes** (knowledge, attitudes, intentions)	**Longer-term Impacts**
What is the health status of children, adolescents, and young adults in our community?	What do state statutes say school districts can and cannot do related to HGD? What is the role of the HGD Advisory Committee? What support do teachers need to provide effective HGD instruction?	How can the school support parents in their role as primary sexuality educators of their children? What HGD curriculum is most likely to be effective and acceptable in our community?	What do our students know and what can they do as a result of HGD instruction? To what extent does youth behavior promote health or reflect health risks?	What is the health status of children, adolescents, and young adults in our community?
See Section 3: Profile of WI Youth	See Section 2: State Statutes Section 4: HGD Advisory Committee Section 7: Professional Development	See Section 5: Parental Communication and Involvement Section 6: Effective HGD Curriculum, Instruction	See Section 6: Effective HGD Curriculum, Instruction	See Section 3: Profile of WI Youth

2.0 STATE STATUTES

OVERVIEW

Wisconsin statutes support human growth and development (HGD) instruction. Relevant statutes include:

Wis. Stat. 115.35	Critical health problems education
Wis. Stat. 118.01	Educational goals and expectations, including instruction in physiology, hygiene, and sexually transmitted diseases
Wis. Stat. 118.019	Human growth and development instruction

The Wisconsin statutes are explained below. Copies of the statutory language can be found in subsequent pages and on the web at **http://www.legis.state.wi.us/rsb/**. Districts are advised to consult with their legal counsel for interpretation and application for local issues.

STATUTES[♣]

Wisconsin Statute 115.35 authorizes the Department of Public Instruction (DPI) to establish a critical health problems education program that includes specific topics such as sexually transmitted diseases, including acquired immunodeficiency syndrome. It gives the DPI authority to establish guidelines to help school districts develop comprehensive health education programs and prohibits the DPI from requiring school boards to use a specific human growth and development curriculum. This statute also states that participation in the human growth and development program is voluntary.

Wisconsin Statute 118.01 identifies educational goals and expectations of public education, and as part of the goal of personal development states that each school board shall provide an instructional program designed to give pupils knowledge of the human body and the means to maintain lifelong health. Section 118.01(2)(d)2c continues that instruction in physiology and hygiene shall include instruction on sexually transmitted diseases and shall be offered in every high school. However, no student may be required to take instruction in these subjects if their parent/guardian files a written objection with the teacher. In such cases, the student cannot be penalized in any way for not taking the instruction but can be required to complete an alternative assignment if the subject is needed for graduation.

Wisconsin Statute 118.01(2)(d)8 requires school districts to provide to students in elementary school "knowledge of effective means by which pupils may recognize, avoid, prevent and halt physically or psychologically intrusive or abusive situations which may be harmful to pupils, including child abuse, sexual abuse and child enticement." This statute requires a school district to provide a protective behaviors curriculum at the elementary level.

[♣] Statute language current as of July 1, 2006.

Wisconsin Statute 118.019 encourages school districts to provide a developmentally appropriate HGD instructional program in grades kindergarten to 12 to promote accurate and comprehensive knowledge and responsible decision making. The statute specifically identifies instructional topics, including self-esteem, responsible decision making, and personal responsibility; interpersonal relationships; discouragement of adolescent sexual activity, family life, and skills required of a parent; human sexuality; reproduction; family planning as defined in Wis. Stat. 253.07 (1) (a), including natural family planning; human immunodeficiency virus and acquired immunodeficiency syndrome; prenatal development, childbirth; adoption; available prenatal and postnatal support; and male and female responsibility; and sex stereotypes and protective behavior.

If a school board provides instruction in human sexuality; reproduction; family planning as defined in Wis. Stat. 253.07 (1) (a), including natural family planning; human immunodeficiency virus and acquired immunodeficiency syndrome; prenatal development, childbirth; adoption; available prenatal and postnatal support; and male and female responsibility, it must also provide instruction in marriage and parental responsibility as part of the same course, during the same school year.. Also, **2005 Wisconsin Act 445,** effective **July 1, 2006** will mandate instruction to do the following:
1. Presents abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried pupils.
2. Emphasizes that abstinence from sexual activity before marriage is the most effective way to prevent pregnancy and sexually transmitted diseases, including human immunodeficiency virus and acquired immunodeficiency syndrome

The statute requires the school board on an annual basis provide parents of each pupil enrolled in the school district with an outline of the human growth and development curriculum used in the pupil's grade level and information regarding how the parent may inspect the complete curriculum and instructional materials. In addition, the curriculum and instructional materials must be made available for inspection at any time upon request.

Students can be exempted from HGD instruction if the student's parent files a written request with the teacher or school principal.

In addition, this statute requires that any school district that offers a HGD curriculum must appoint an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy and other residents of the school district to develop and review the curriculum at least every three years. The term "develop" can be interpreted in the broad sense of ongoing development and evolution. If interpreted in this way, the advisory committee does not necessarily write the curriculum's lessons, especially if the school district has a curriculum in place. Feedback, edits, decisions on topics, and timing are all effective ways for a committee to work and develop a curriculum. In some cases the committee will actually develop and write lessons for the curriculum.

GUIDELINES FOR OPT-OUT POLICIES

The state does not require parents to give permission for HGD instruction; however, Wis. Stat. 118.019 allows parents to exempt their child from instruction in human growth and development with a written request to the teacher or principal. This is referred to as an "opt-out" policy. Wisconsin Statute 118.01(2)(d)2c permits pupils to be exempted from instruction on physiology and hygiene, STDs, symptoms of disease and the proper care of the body if his or her parent files a written request with the teacher or school principal. Typically a school will provide parents with an opt-out form when they provide them with the HGD curriculum outline. Wisconsin statutes do not provide, and legislative history does not support, the use of the parent "opt-in" method by local school districts where the "opt-out" method is statutorily specified. The opt-in method would require a parent to notify their child's principal/teacher if they want their child to take instruction in HGD.

Resource 2.1

Statute 115.35

115.35 Health problems education program. (1) A *critical health problems education program is established in the department* [emphasis added]. The program shall be a systematic and integrated program designed to provide appropriate learning experiences based on scientific knowledge of the human organism as it functions within its environment and designed to favorably influence the health, understanding, attitudes and practices of the individual child which will enable him or her to adapt to changing health problems of our society. The program shall be designed to educate youth with regard to critical health problems and shall include, but not be limited to, the following topics as the basis for comprehensive education curricula in all elementary and secondary schools: controlled substances, as defined in s. 961.01 (4); controlled substance analogs, as defined in s. 961.01 (4m); alcohol; tobacco; mental health; *sexually transmitted diseases, including acquired immunodeficiency syndrome; human growth and development* [emphasis added]; and related health and safety topics. Participation in the human growth and development topic of the curricula shall be entirely voluntary. The department may not require a school board to use a specific human growth and development curriculum.

(2) In carrying out this section, the state superintendent may, without limitation because of enumeration:

(a) Establish guidelines to help school districts develop comprehensive health education programs.

(b) Establish special in-service programs to provide professional preparation in health education for teachers throughout the state.

(c) Provide leadership institutions of higher education to develop and extend curricula in health education for professional preparation in both in-service and preservice programs.

(d) Develop cooperative programs between school districts and institutions of higher education whereby the appropriate health personnel of such institutions would be available to guide the continuing professional preparation of teachers and the development of curricula for local programs.

(e) Assist in the development of plans and procedures for the evaluation of health education curricula.

(3) The department may appoint a council consisting of representatives from universities and colleges, law enforcement, the various fields of education, the voluntary health agencies, the department of health and family services, the professional health associations and other groups or agencies it deems appropriate to advise it on the implementation of this section, including teachers, administrators and local school boards.

(4) The department shall cooperate with agencies of the federal government and receive and use federal funds for the purposes of this section.

(5) In each report under s. 15.04 (1) (d), the state superintendent shall include information:

(a) As to the scope and nature of programs undertaken under this section.

(b) As to the degree and nature of cooperation being maintained with other state and local agencies.

(c) As to the state superintendent's recommendations to improve such programs and cooperation.

History: 1971 *c.* 219; 1977 c. 196 *s.* 131; 1977 *c.* 418; 1981 c. 291; 1985 a 56; 1989 a.203; 1993.492;1995 a. 27 as. 3873, 9126 (19), 9145 (1); 1995 a. *Mt* 1997 a. 27.

Resource 2.2

Statute 118.01

118.01 Educational goals and expectations. (1) Purpose. Public education is a fundamental responsibility of the state. The constitution vests in the state superintendent the supervision of public instruction and directs the legislature to provide for the establishment of district schools. The effective operation of the public schools is dependent upon a common understanding of what public schools should be and do. Establishing such goals and expectations is a necessary and proper complement to the state's financial contribution to education. Each school board should provide curriculum, course requirements and instruction consistent with the goals and expectations established under sub. (2). Parents and guardians of pupils enrolled in the school district share with the state and school board the responsibility for pupils meeting the goals and expectations under sub. (2).

(2) EDUCATIONAL GOALS. (a) Academic skills and knowledge. Since the development of academic skills and knowledge is the most important goal for schools, each school board shall provide an instructional program designed to give pupils:

I. Basic skills, including the ability to read, write, spell, perform basic arithmetical calculations, learn by reading and listening and communicate by writing and speaking.

2. Analytical skills, including the ability to think rationally, solve problems, use various learning methods, gather and analyze information, make critical and independent judgments and argue persuasively.

3. A basic body of knowledge that includes information and concepts in literature, fine arts, mathematics, natural sciences, including knowledge of the elements of agriculture and the conservation of natural resources, and social sciences, including knowledge of the rights and responsibilities of the family as a consumer, cooperative marketing and consumers' cooperatives.

4. The skills and attitudes that will further lifelong intellectual activity and learning.

5. Knowledge in computer science, including problem solving, computer applications and the social impact of computers.

(b) Vocational skills. Each school board shall provide an instructional program designed to give pupils:

1. An understanding of the range and nature of available occupations and the required skills and abilities.

2. Preparation to compete for entry level jobs not requiring postsecondary school education.

3. Preparation to enter job-specific vocational training programs.

4. Positive work attitudes and habits.

(c) Citizenship. Each school board shall provide an instructional program designed to give pupils:

1. An understanding of the basic workings of all levels of government, including the duties and responsibilities of citizenship.

2. A commitment to the basic values of our government, including by appropriate instruction and ceremony the proper reverence and respect for and the history and meaning of the American flag, the Declaration of Independence, the U.S. constitution and the constitution and laws of this state.

3. The skills to participate in political life.

4. An understanding of the function of organizations in society.

5. Knowledge of the role and importance of biological and physical resources.

6. Knowledge of state, national and world history.

7. An appreciation and understanding of different value systems and cultures.

8. At all grade levels, an understanding of human relations, particularly with regard to American Indians, Black Americans and Hispanics.

(d) Personal development. Each school board shall provide an instructional program designed to give pupils:

1. The skills needed to cope with social change.

2. Knowledge of the human body and the means to maintain lifelong health, including:

a. Knowledge of the theory and practice of physical education, including the development and maintenance of physical fitness;

b. Knowledge of the true and comparative vitamin content of food and food and health values of dairy products and their importance for the human diet; and

c. *Knowledge of physiology and hygiene* [emphasis added], sanitation, the effects of controlled substances under ch. 961 and alcohol upon the human system, symptoms of disease and the proper care of the body. No pupil may be required to take instruction in these subjects if his or her parent files with the teacher a written objection thereto. If a pupil does not take instruction in these subjects as a result of parental objection, the pupil may not be required to be examined in the subjects and may not be penalized in any way for not taking such instruction, but if the subjects receive credit toward graduation, the school board may require the pupil to complete an alternative assignment that is similar to the subjects in the length of time necessary to complete. *Instruction in physiology and hygiene shall include instruction on sexually transmitted diseases and shall be offered in every high school.* [Emphasis added.]

3. An appreciation of artistic and creative expression and the capacity for self–expression.

4. The ability to construct personal ethics and goals.

5. Knowledge of morality and the individual's responsibility as a social being, including the responsibility and morality of family living and the value of frugality and other basic qualities and principles referred to in article I, section 22, of the constitution insofar as such qualities and principles affect family and consumer education.

6. Knowledge of the prevention of accidents and promotion of safety on the public highways, including instruction on the relationship between highway safety and the use of alcohol and controlled substances under ch. 961.

7. The skills needed to make sound decisions, knowledge of the conditions which may cause and the signs of suicidal tendencies, knowledge of the relationship between youth suicide and the use of alcohol and controlled substances under ch. 961 and knowledge of the available community youth suicide prevention and intervention services. Instruction shall be designed to help prevent suicides by pupils by promoting the positive emotional development of pupils.

8. Knowledge of effective means by which pupils may recognize, avoid, prevent and halt physically or psychologically intrusive or abusive situations which may be harmful to pupils, including child abuse, sexual abuse and child enticement. Instruction shall be designed to help pupils develop positive psychological, emotional and problem–solving responses to such situations and avoid relying on negative, fearful or solely reactive methods of dealing with such situations. Instruction shall include information on available school and community prevention and intervention assistance or services and shall be provided to pupils in elementary schools.

History: 1983 a. 412; 1985 a. 29, 213; 1989 a. 31; 1995 a. 27, 229, 448; 1997 a. 27, 35.

Resource 2.3

Statute 118.019

118.019 Human growth and development instruction. (1) PURPOSE. The purpose of this section is to encourage all school boards to make available to pupils instruction in topics related to human growth and development in order to promote accurate and comprehensive knowledge in this area and responsible decision making and to support and enhance the efforts of parents to provide moral guidance to their children.

(2) SUBJECTS. A school board may provide an instructional program in human growth and development in grades kindergarten to 12. If provided, the program shall offer information and instruction appropriate to each grade level and the age and level of maturity of the pupils. Except as provided in sub. (2m), the program may include instruction in any of the following areas:

(a) Self–esteem, responsible decision making and personal responsibility.

(b) Interpersonal relationships.

(c) Discouragement of adolescent sexual activity.

(d) Family life and skills required of a parent.

(e) Human sexuality; reproduction; family planning, as defined in s. 253.07(1)(a), including natural family planning; human immunodeficiency virus and acquired im-munodeficiency syndrome; prenatal development; childbirth; adoption; available prenatal and postnatal support; and male and female responsibility.

(f) Sex stereotypes and protective behavior.

(g) (2m) (a) MARRIAGE AND PARENTAL RESPONSIBILITY. If a school board provides instruction in any of the areas under sub. (2) (e), the school board shall ensure that instruction in marriage and parental responsibility is provided in the same course, during the same school year, as the area under sub. (2) (e).

(2m) (b) The school board shall ensure that instruction related to the areas under sub. (2) (e) does all of the following:

1. Presents abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried pupils

2. Emphasize that abstinence from sexual activity before marriage is the most effective way to prevent pregnancy and sexually transmitted diseases, including human immunodeficiency virus and acquired immunodeficiency syndrome

(3) DISTRIBUTION OF CURRICULUM TO PARENTS. Each school board that provides an instructional program in human growth and development shall annually provide the parents of each pupil enrolled in the school district with an outline of the human growth and development curriculum used in the pupil's grade level and information regarding how the parent may inspect the complete curriculum and instructional materials. The school board shall make the complete human growth and development curriculum and all instructional materials available upon request for inspection at any time, including prior to their use in the classroom.

(3) EXEMPTION FOR INDIVIDUAL PUPILS. No pupil may be required to take instruction in human growth and development or in the specific subjects under sub. (2) if the pupil's parent files with the teacher or school principal a written request that the pupil be exempted.

(4) ADVISORY COMMITEE. In any school district that offers a human growth and development curriculum, the school board shall appoint an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy and other residents of the school district. The advisory committee shall develop the human growth and development curriculum and advise the school board on the design, review and implementation of the advisory committee's human growth and development curriculum. The advisory committee shall review the curriculum at least every 3 years.

—History: 1985 *a 56;* 1957 *a 399;* 1989 *a* 203; 1995 *a. 27;* 1997 *a. 27; 2001 a. 16.*

3.0 PROFILE OF WISCONSIN YOUTH

OVERVIEW

Information about the attitudes, behaviors, and health outcomes of young people provides an important foundation for parents, schools, and other youth advocates to use to determine developmentally appropriate and timely messages, skills, and services to support young people's healthy development and well-being. Acquiring an accurate profile of young people in a community can be difficult. There are limited scientific data on adolescent sexual behavior, and most of what does exist is available at the national or state level. Each community will need to identify which measures of attitudes, behaviors, and health outcomes will be most important to consider, in part based on what is available or can be acquired. It is not necessary to obtain a lengthy list of measures of youth attitudes, behavior, and health outcomes. What should be priority measures are those that are critical to the goals of the human growth and development (HGD) program. Local school districts usually use state or national data as a beginning point, and then supplement these data with local data that better describes the local situation. The better the understanding of the attitudes, sexual behaviors, and sexual health outcomes of youth in the community, the more likely it is that a HGD program can be developed to meet their needs.

Data is useful for a number of reasons. Perhaps most important, it can help school districts identify adolescent behaviors in need for attention and priority, and then serve as benchmarks from which school districts and communities can measure progress in addressing these aspects of adolescent health. The state health plan suggests goals to address individual adolescent behavior change, and also goals related to the social environment that enhances healthy adolescent development, including adoption of healthy behaviors. In addition to measures of risk behaviors, school districts are increasingly using youth development indicators as broader measures of adolescent health and well-being. Such measures focus on assets, resiliencies, and strengths of young people and recognize the importance of family, school, and community factors to provide a supportive environment in which young people develop.

Many districts find that quantitative data do not exist for all behaviors, environmental factors, and youth development indicators for which measures would be helpful. School districts must determine what data is accessible, what is realistic to collect, and what may be sufficient for their needs. When local data is not available there may be national or state data that can be used. There also may be qualitative data, such as results from focus groups or interviews, which can be useful in developing a profile of youth in the community.

Knowledge and Attitudes – Teachers use various strategies to assess student learning. A district may consider using selected learning assessments over time to measure trends in what students know and learn to assess the effectiveness of the HGD instructional program.

Behaviors – The following indicators are commonly used to describe prevalence of behaviors in a population:

- Percentage of youth not sexually active
- Age of first intercourse
- Percentage of youth who are sexually active
- Number of sexual partners
- Alcohol and drug use before last sexual intercourse
- Contraceptive use at last sexual intercourse

Health Outcomes – This type of data measures the longer term goals of HGD programs. Because there are many factors which contribute to these outcomes within a community, it is seldom possible to attribute a school-based HGD program for changes in these indicators, but an effective HGD program can contribute to positive health outcomes. Commonly used measures of health outcomes include:

- Pregnancy rate
- Birth rate
- STD rate
- Abortion rate
- Cases of HIV

Youth Development – These indicators attempt to measure youth characteristics, assets, and competencies, as well as the environmental factors that contribute to youth development. Some of the commonly used indicators are:

- Aspects of identity (feelings of confidence, well-being, connections and commitment to others)
- Areas of ability (behaviors that enhance physical and mental health, employment, civic and social engagement)
- Supportive relationships with caring adults (family, school, community)
- Opportunities for personal development and meaningful involvement

This section briefly reviews key aspects of typical child development, and then reviews what is known from state and national data about the attitudes and sexual behavior of youth, and provides suggestions for acquiring local data to describe the status of young people in a particular community.

WHAT WE KNOW: CHILD DEVELOPMENT

Development is a complex process that involves physical development, psychosocial development, and cognitive development. During a child's school years some physical changes will occur slowly, while at other times children will experience rapid physical growth spurts and physiological changes. The psychosocial development process is influenced by family, peer, school, and other factors, and is a process of exploration and experimentation through which children develop competence, the ability to manage emotions, a sense of autonomy and identity, meaningful relationships, and integrity reflecting their personal and family values. Although there are general characteristics that describe children at various developmental stages, it is important to remember that each

child will develop physically, psychosocially, and cognitively at his or her own rate based on numerous factors including his or her personality, family, culture, and community.

Early Elementary – The pre-school and kindergarten years are characterized as the "play age" and "years of magic" as children move about, develop social skills, and express curiosity about their world. Children ages 5-8 years of age continue to be curious about many things, including their own bodies. Children become more aware of similarities and differences, and may express their curiosity by asking questions. Many are also curious about pregnancy and birth.

In terms of social development, children are learning about being a friend. Children have more opportunities to select their friends and most children this age prefer to play with children of the same gender. Children are becoming aware of socially defined roles, especially related to gender. Children are also becoming more aware of what their peers think, especially as friendships become increasingly important. It is also a period during which children begin to develop empathy and understand the feelings of others. As children are taught numerous skills related to social interactions it is important to include instruction on protective behaviors, or child sexual abuse prevention. Children this age are concrete learners, and school provides a setting to teach developmentally-appropriate content and skills through which children begin to gain a sense of competence.

Upper Elementary and Middle School – Children in upper elementary school and middle school experience the most rapid physical, social and emotional development since the growth spurt they experienced as infants and toddlers. Puberty, the stage during which a person becomes capable of sexual reproduction, may begin as early as 8 or 9 years of age or as late as 15 or 16 and usually takes four or five years to complete. This is a stage during which children are more aware of changes in their bodies and frequently wonder, "Am I normal?" It may be helpful for teachers and parents to reinforce the following important messages about puberty for both boys and girls (Haffner, 1999):

- Puberty begins and ends at different ages for different people.
- Everyone's body changes at its own pace.
- Most changes in puberty are similar for boys and girls.
- Girls often begin pubertal changes before boys.
- Preadolescents may feel uncomfortable, clumsy, and/or self-conscious because of the rapid changes in their bodies.
- The sexual and reproductive systems mature during puberty. Girls begin to ovulate and menstruate, and boys begin to produce sperm and ejaculate.
- Emotional changes also occur during puberty. Young people may begin to develop romantic and sexual feelings.

In addition to noticeable changes in physical development, children experience significant changes in their social and emotional development. Young people may increasingly identify with, and spend time with, their peer groups and begin to separate from their families. Peer pressure may become more apparent. Some early adolescents become interested in dating and may experience intense emotions as part of these

relationships. Young people this age are targeted by, and susceptible to, media messages, including messages about gender roles, expression of sexual intimacy, and body image. Because young adolescents are developing abstract thinking, school-based HGD instruction can provide important content information and opportunities for young people to develop skills to successfully manage and negotiate potential challenging situations.

High School and Adolescence – Adolescence, the period between puberty and adulthood, is a period of changes, challenges, and new experiences. By this time most young people have completed most of the physical changes associated with puberty and their major growth spurt. Recent research shows that neurological development is an important aspect of adolescent development, and some parts of this brain development aren't completed until young people are in their mid-20's (Weinberger et al, 2005). This is particularly significant as a factor in understanding adolescent sexual behavior. For example, the prefrontal cortex, the region associated with impulse control, planning and decision-making functions, is one of the last areas of the brain to fully mature. Given the numerous changes, challenges, and new experiences that take place during this stage of development, adolescence is a period during which a young person:

- Adjusts to a new self-image based on a physically mature body.
- Develops a personal identity, including their gender identity and sexual orientation.
- Develops a personal identity based on personal values, ethics and behavior.
- Increases independence, including a redefinition of relationships and communication patterns with parents/guardians, siblings and peers.
- Establishes intimate relationships involving emotional and physical attraction and intimacy.
- Increasingly develops skills to set priorities, make decisions, organize plans, form strategies, and control impulses.

In general, it is a period during which young people continue to develop a sense of self as they develop answers to, "Who am I?" and "What am I capable of doing?" Sexual topics (including dating, relationships, sexual behavior, abstinence, contraception, safer sex, etc.) are of interest to many adolescents. It is a period during which youth are bombarded with conflicting messages about sexuality from the media, music, parents/guardians, teachers, and other influential adults. For a significant number of young people it is a time of sexual debut, or first intercourse, although the percentage of high school students who report being sexually active continues to decline.

At this stage of development some young people continue to believe they are invincible in the face of risk behaviors, or that potential negative health outcomes will not happen to them. For most adolescents the capacity for abstract thinking continues to develop. By late adolescence, roughly ages 16-18, young people have developed more independence from their parents, and a set of values, morals and ethics from which they are able to specify general life goals and career plans.

References:

Haffner DW. *From Diapers to Dating: A Parent's Guide to Raising Sexually Healthy Children*. New York: Newmarket Press. . (1999).

Sexuality Education Within Comprehensive School Health Education. 2nd edition. Kent, Ohio: American School Health Association (2003).

Weinberger, DR, Elvevag, B, Giedd, JN. *The Adolescent Brain: A Work in Progress*. The National Campaign to Prevent Teen Pregnancy. Washington, D.C. (2005). Available at www.teenpregnancy.org/resources/reading/pdf/BRAIN.pdf.

WHAT WE KNOW: ATTITUDES

Surveys of attitudes of youth, as well as assessments of public opinion, provide useful supplements to the behavioral data discussed below. In recent years the National Campaign to Prevent Teen Pregnancy has conducted *With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy*, an annual national survey of adults (aged 20 and older) and teens (aged 12-19) about teen pregnancy and related issues. The results from this national survey underscore the importance of parents as powerful influences in their children's lives. The survey results indicate:

- Parents continue to underestimate their influence on their teenagers' decisions about sex.
- Support for providing young people with a strong abstinence message is overwhelming.
- Support is also strong for giving young people information about contraception.
- Few teens, however, feel that they are getting enough information about both abstinence and contraception.
- The clear majority of adults and teens believe that teens should not be sexually active but teens who are should have access to contraception.
- Teens continue to express more cautious attitudes toward sex than is perhaps generally believed.
- Teens overestimate the percentage of their peers who have had sex.
- Adults mistakenly believe that rates of teen sexual activity and pregnancy have been increasing over the past several years.

The authors of the report conclude "…the majority of adults and teens in this country continue to hold a practical, moderate view about teen sexual behavior and pregnancy prevention."

WHAT WE KNOW: BEHAVIORS

Youth Risk Behavior Survey (State Level Data)

The Wisconsin Youth Risk Behavior Survey (YRBS) is conducted as part of a national effort by the U.S. Centers for Disease Control and Prevention (CDC) to monitor health-risk behaviors of the nation's high school students. In Wisconsin, the survey has been administered every two years beginning in 1993, and as such it provides valuable longitudinal data. The 2005 survey addressed eight priority areas, including protective assets; traffic safety; weapons and violence; suicide; tobacco use; alcohol and other drug use; sexual behavior; and diet, nutrition and exercise. It was administered to 2389 students in 52 public high schools in Wisconsin in the spring of 2005 and the survey results are representative of 9th through 12th grade public high school students in Wisconsin. With regard to sexual behavior, the 2005 YRBS found:

- Thirty-seven percent of students said that it was important for them to delay having sexual intercourse until they were married, engaged, or an adult in a long-term, committed relationship.

- Overall, student reports of risky sexual behavior have decreased significantly between 1993 and 2005.

- The prevalence of high school students who reported having ever had sexual intercourse decreased significantly from 47% in 1993 to 40% in 2005.

- The prevalence of high school students who reported being currently sexually active, defined as having had sexual intercourse in the past 3 months decreased slightly from 32% in 1993 to 29% in 2005. Twenty-seven percent of male students compared to 32% of female students reported being currently sexually active.

- The percentage of sexually active students reporting using a condom increased from 58% in 1993 to 65% in 2005. Sixty-nine percent of sexually active male students compared to 62% of sexually active female students reporting using a condom the last time they had sex.

- The majority of sexually active students reported using a reliable form of birth control the last time they had sex. Seventy-eight percent of students reported using a condom, birth control pill, or Depo-Provera before their last sexual intercourse.

- About one in four high school students reported using alcohol or drugs before the last time they had intercourse. Male students were significantly more likely to report this behavior than female students (27% compared to 19%, respectively).

These and other findings from the Wisconsin Youth Risk Behavior Survey are available at **www.dpi.wi.gov/sspw/yrbsindx.html**.

See Resource 3.1 **Profile of Wisconsin Youth: Key Points 2005**
See Resource 3.2 **What Do I Know and Not Know About the Sexual Behaviors of Wisconsin Youth?**

WHAT WE KNOW: HEALTH OUTCOMES

State Health Plan Objectives

Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public was designed to articulate a vision of public health and state goals and objectives for the next 10 years to achieve the vision of healthy people in healthy communities in Wisconsin. The plan is available at: **www.dhfs.wi.gov/health/statehealthplan.** Based on statewide rates, Wisconsin tends to have lower rates of risky sexual behaviors and negative health outcomes than the national averages. Nevertheless, some rates are unacceptably high. High risk sexual behavior, including high risk sexual behavior of adolescents, is one of the 11 health priorities identified by Wisconsin's state health plan. The objectives related to adolescents and sexuality are:

Objective #1: Adolescent Sexual Activity – A decrease in the proportion of Wisconsin high school youth who report ever having sexual intercourse to 30% by the end of 2010.

Objective#2: Unintended Pregnancy in Wisconsin – By 2010, reduce the percentage of unintended pregnancies among Wisconsin residents to 30%.

Objective #3: Sexually Transmitted Infection, Including HIV Infection – Promote responsible sexual behavior throughout the life span, strengthen community capacity, and increase access to quality services to prevent sexually transmitted infection, including HIV infection.

Because of the public attention and public health commitment to these objectives, school districts have public health partners in their communities who are also interested in implementing effective programs to reduce the number of young people engaging in high risk sexual behaviors.

Teenage Pregnancy Statistics

- According to the most recent data (2000, cited in the Wisconsin State Health Plan), there were 99 births to teens under age 15 and 2,225 to young women 15-17 years old in 2000.

- The following table illustrates pregnancy outcomes among females aged 15-19 in Wisconsin in 2000.

Indicator	Number	Percent	Rate per 1,000
Pregnancies	10,980	100%	55
Births	6,977	64%	35
Abortions (estimate)	2,370	22%	12
Miscarriages/stillbirths (estimate)	1,630	15%	8

Source: U.S. Teenage Pregnancy Statistics, The Alan Guttmacher Institute, updated February 19, 2004 and presented by Neil Hoxie at the Adolescent Sexual Risk Behavior Prevention Institute, August 5-6, 2005.

A rate of 55 pregnancies per 1000 females ages 15-19, is equivalent to one pregnancy for every 18 females 15-19 years old. A comparable figure for the United States is one pregnancy for every 12 females, or 84 pregnancies per 1000 females ages 15-19.

A closer look at these figures provide insight into health disparities based on race/ethnicity. The pregnancy rates for 1,000 females aged 15-19 in Wisconsin (2000) were 177 for African Americans, 137 for Hispanics, and 39 for Whites. In other words, there was 1 pregnancy for every 5.6 young African American women ages 15-19, 1 pregnancy for every 7.3 young Hispanic women, and 1 pregnancy for every 25.6 young white women.

- Abortion rate (2000) was 12 per 1000 women ages 15-19 compared to a rate of 24 nationwide.

- Birth rate (2002) was 32 per 1000 women ages 15-19 compared to a rate of 43 nationwide.

- Nationally, and in Wisconsin, the teenage pregnancy rate is down. Since 1988 teen pregnancy rates have declined 24% nationwide and 26% in Wisconsin. (See **www.agi-usa.org/pubs/state_pregnancy_trends.pdf**)

- Both abstinence and increased use of contraceptives are believed to be responsible for the decline in teen pregnancy rates (Darroch Je and Singh S. (1999). “Why is teenage pregnancy declining? The roles of abstinence, sexual activity and contraceptive use.” *Occasional Report*, New York: AGI, No. 1.

Sexually Transmitted Infections

- STIs represent the largest group of communicable diseases in Wisconsin and can have significant consequences for young people. Potential health consequences include reproductive cancers, pelvic inflammatory disease, infertility, ectopic pregnancy, and HIV/AIDS. Potential consequences include the emotional stress related to communicating with partners about the STI diagnosis and physical health consequences.

- In Wisconsin, about one third of reportable STIs are among persons under 20 years of age (Hoxie, N., "Pregnancy, STI, and HIV Among Wisconsin Youth" presented at DPI's Sexual Risk Behavior Prevention Institute, August 5-6, 2005.)

- Additional Wisconsin statistics are available at **http://dhfs.wisconsin.gov/communicable/STD/Statistics.htm**.

HIV/AIDS

- In Wisconsin 213 adolescents (age 13 to 19) have been diagnosed with HIV infection (through December 31, 2004 as reported in the Wisconsin HIV/AIDS Quarterly Surveillance Summary, *Wisconsin AIDS/HIV Update*, Winter 2005.)

- The proportion of newly-identified HIV cases in the US among persons under 25 has increased since 1994 and the CDC estimates that half or more of all HIV infections occur before age 25 (Centers for Disease Control and Prevention. (2002b) Table 14: HIV infection cases in adolescents and adults under age 25, by sex and exposure category, reported through June 2001, from 34 areas with confidential HIV infection reporting. Available at **www.cdc.gov/hiv/stats/hasr1301/table14.htm**.

- The proportion of HIV-infected females was highest among persons aged 13-19 years (Centers for Disease Control and Prevention (2004b). Heterosexual Transmission of HIV – 29 states. *Morbidity and Mortality Weekly Report*, 43(06), 125-129 (1999-2002).)

- Certain groups of adolescents are at higher risk for HIV infection. These include adolescents of color, adolescents who are homeless, males who have sex with males, gay, bisexual and transgender adolescents, adolescents who inject drugs, victims of sexual abuse, adolescents who are mentally ill, and adolescents in the juvenile justice or foster care system. (D. Futterman, B. Chabon, & N.D. Hoffman. HIV and AIDS in adolescents. *Pediatric Clinics of North America*, 47(1), 171-188. (2000).)

- Young people are concerned about HIV/AIDS, but many do not perceive themselves to be personally at risk and lack accurate information about the circumstances and situations that put them at risk. Henry J. Kaiser Family

Foundation. *Sex Education in America: A View from Inside the Nation's Classrooms.* (2000). **www.kff.org/youthhivstds/3048-index.cfm**.

- Males who have sex with males continue to constitute the majority of adolescents living with and/or newly-infected with HIV (Centers for Disease Control and Prevention. (2001). *Young People at Risk: HIV/AIDS Among America's Youth* (internet). Available at **www.cdc.gov/hiv/pubs/facts/youth.pdf** and Centers for Disease Control and Prevention (2002). Need for sustained HIV prevention among men who have sex with men. March 11, 2002. Available at **www.cdc.gov/hiv/pubs/facts/msm.pdf**.

See Resource 3.3 National Surveys of Adolescent Sexual Attitudes and Behaviors

WHAT WE KNOW: YOUTH DEVELOPMENT

In addition to health behaviors and health outcomes, it is often useful to assess the extent to which young people develop assets and competencies which help them avoid problem behaviors. According to an increasing youth development literature, youth develop competencies, resiliencies and assets when they have sufficient support and opportunities from families, other caring adults, schools and communities. A number of instruments to measure youth development indicators are listed in the Youth Development Measures resource included at the end of this section.

See Resource 3.4 Youth Development Measures

WHAT WE KNOW: SPECIAL POPULATIONS

Sexual Minority Youth

Limited data exist about the experience of lesbian, gay, bisexual and transgender (LGBT) youth, including their knowledge, attitudes, perceived support, risk behaviors, and health outcomes. Many people are unaware of ways in which school and community environments affect LGBT youth, including lower self-esteem related to harassment (Girl's Best Friend Foundation and Advocates for Youth, 2005). GLSEN, the Gay Lesbian and Straight Educators' Network, conducted its third National School Climate Survey in 2005. The survey used a convenience sample of LGBT youth involved in community-based organizations and individuals who accessed the survey through the GLSEN web site. Results from convenience samples should be interpreted with caution as they only represent the people responding to the survey. This survey is the only national survey documenting the experiences of sexual minority youth in America's high schools. The survey concluded that many LGBT youth face harassment and discrimination in schools and the negative impact of a hostile school environment affects students' sense of belonging in school, academic performance and college aspirations.
Risk Behaviors. Between the years of 1997 and 2001 the Wisconsin YRBS asked whether students had been threatened or hurt because someone thought they were gay, lesbian, or bisexual. An analysis of YRBS data from 1997, 1999, and 2001 found

students who reported being threatened or hurt because of their perceived sexual orientation were more likely than other high school age youth to engage in high risk behavior on almost every indicator assessed. A summary of these findings are included as Resource 3.5: Wisconsin YRBS LGBT Correlation Analysis.

Health Outcomes. Many LGBT youth face environments in which they experience verbal and physical abuse related to sexual orientation. Some LGBT youth are at particularly high risk for negative health outcomes, including substance abuse, suicide, teen pregnancy, and other negative health outcomes. Fortunately there is also some evidence that when environmental and social supports are provided, differences in rates of negative health outcomes between LGBT youth and their heterosexual peers diminish or disappear (Safren and Heimberg, 1999).

Young gay men, or men who have sex with other men, are at particularly high risk for HIV transmission. This health disparity is particularly noticeable and unacceptable among young men of color who have sex with men. In 2001, 50% of all AIDS cases among young men 13 to 24 years old in the United States were reported among men who have sex with men (MSM) (Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 2001; 13(2)). In Wisconsin, 59% percent of all cases of AIDS have been among men who have sex with men (with an additional 7% in the exposure category of men who have sex with men and inject drugs) (Wisconsin AIDS/HIV Update, 2005). It is likely that many of these individuals acquired HIV infection as teens or young adults.

School-based HGD programs provide an opportunity to reach all youth, including young gay men, before risky behaviors are initiated or established (Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention (CDC/DHAP). *Young People at Risk: HIV/AIDS Among America's Youth*. March, 2002. Available at **www.cdc.gov/hiv/pubs/facts/youth.htm**.)

References:

Girl's Best Friend Foundation & Advocates for Youth (2005). Creating Safe Space for GLBTQ Youth: A Toolkit. Available at www.advocatesforyouth.org

J. Kosciw. *The 2003 National School Climate Survey: The School-Related Experiences of Our Nation's Lesbian, Gay, Bisexual, and Trangender Youth*. Gay, Lesbian, and Straight Education Network (GLSEN). New York. (2004).

S.A. Safren & R.G. Heimberg. Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clnical Psychology*. 67;6:859-866. (1999).

Wisconsin AIDS/HIV Update.Wisconsin HIV/AIDS Quarterly Surveillance Summary through December 31, 2004. p. 37. Winter 2005.

See Resource 3.5 Wisconsin YRBS LGBT Correlation Analysis

Children and Youth with Disabilities

All children, including children with emotional/behavioral, physical, cognitive, communication, or learning disabilities, need accurate information to learn about their developing sexuality. In addition to learning about physical changes they will experience, children and youth will benefit from opportunities and support to develop social skills, respectful and meaningful relationships with other people, and other relevant life skills related to sexuality. The type and onset of the disability may affect the way in which information is most effectively presented as well as the type of information presented. For example, children and youth with learning or cognitive disabilities may need information presented in small amounts, and in concrete ways. A child with a physical disability may need specific information about how the physical disability affects his or her expression of sexuality.

Numerous challenges may influence the process of learning about sexuality and the sexual development of children and youth with disabilities. Cole (2001) explains:

> In many situations, chronological age of the child will not be consistent with the maturational or emotional age. Many factors can influence this delay – mobility limitations which require a great deal of physical assistance in all or many activities, lack of privacy, including the area of personal hygiene, and other daily living experiences which can interfere with spontaneous learning about sexuality. …A congenitally disabled child can experience a great lack of privacy due to excessive personal care needs and perhaps unrealistic assistance or protection from family who wish to protect the child form emotional injury by an insensitive society. The child may experience isolation form peers because interaction takes organization, planning, effort, and assistance. Mobility limitations and lack of privacy are significant factors in alerting or limiting natural sexual development, education, and values. [p. 6]

There are a number of reasons why sexuality education for students with disabilities has been neglected. Some reasons may include the belief that these students do not need to know about sexuality because they will not have sex, the belief that these students will not understand the information, and the myths that people with disabilities are not interested in sex or cannot experience intimacy. In addition, some parents may be more protective of a child with a disability than their child without a disability. This may result in the parent inadvertently or intentionally providing fewer opportunities for their child to develop and practice social skills related to relationships and sexual situations; potentially leading the child to misinformation on developing healthy relationships. Schools have an important role in developing and delivering HGD instruction to meet the needs of their students with disabilities.

The research literature provides parents with recommendations on how to talk with their children with developmental disabilities, which may also be useful for school staff members. One researcher advises (McLaughlin, 2003):

- You may have to initiate the conversation.

- Give age-appropriate (based on the child's biological age) information in a way that the child will understand.
- Take advantage of "teachable moments."
- Simplify your responses and add more information as the child continues to be interested.
- Be patient and provide multiple opportunities to reinforce concepts and skills.
- Find ways to be concrete when teaching the topic.
- Try not to overreact to shocking questions or inappropriate behaviors.
- Provide for practice in a safe setting.
- There's nothing wrong with being embarrassed, and there's nothing wrong with telling the child that you're embarrassed.
- You don't need to know the answer to every question because together you can research the answer.
- If you're thrown by a question, you have the right to answer it later.
- You have the right to pass on personal questions.
- Make sure your words and body language provide a consistent message.
- Ask the child for their opinion.

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J. Coughlan, K.H. Cahil, P. Andrews, C. Jones & M.J. Madison. Sexuality and Social Development. Resources for Professionals on Sexuality and Social Development of Children with Disabilities, New Hampshire Department of Health and Human Services.
Article, Teaching children and youth about sexuality. pp. 9-13 (1995).
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K. McLaughlin. "Tips for Talking about Sexuality," printed in *GULP! Talking with Your Kids About Sexuality*, Planned Parenthood of Northern New England, Vol. 4, No. 1. (May, 2003).

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Children and Youth who are Homeless

It is projected that there are over 1.3 million homeless children and youth on the streets of America each night. (1) Homeless families are the fastest growing segment of the homeless population. (2) **www.familyhomelessness.org/pdf/fact_children.pdf** . It is also estimated that as many as 5% of young people under age 18 are homeless. (3)

Lack of affordable housing is the major reason for homelessness for families in America. Poor and low-income families cannot earn enough income to pay for increasingly expensive housing. For every 100 poor or low-income households, approximately 75 units are affordable.
(**www.hoopsforthehomeless.org/pressroom/PDF/HoopsPaperFinal.pdf**, p. 4).

Homeless children and youth have been defined as individuals who lack a fixed, regular, and adequate nighttime residence. This includes children and youth who are away from home at least one night without the permission of parents, guardians or custodial authorities; young people who move from one friend's home to another (couch surfers); children and youth who have been told or forced to leave home or deserted by parents or guardians (throw aways); children and youth who have run away from home (runaways); youth who manage to live for an extended time on the streets (unaccompanied youth); and children and youth whose families are homeless.

Violence and Homeless Children

Violence affects the lives of many young children experiencing homelessness. Almost 25 percent of homeless children have witnessed acts of violence, while 15 percent have seen their fathers hit their mother. Over 10 percent of homeless children have seen their mother abused by a male partner. In addition, over 65 percent of mothers in homeless families were violently abused by a childhood caretaker or other adult before 18 years of age (4).

There are serious emotional effects for children experiencing violence. These children tend to be more aggressive, antisocial, fearful, and have higher levels of depression and anxiety compared to children who have not experienced violence. Children exposed to violence also have a greater acceptance of using violence as a means for resolving conflict (4). Exposure to violence has an impact on the sexual attitudes of children from homeless households.

Violence and Homeless Youth

The primary causes of homelessness among youth are physical or sexual abuse by a parent or guardian, neglect, parental substance abuse, and family conflict. Sexual abuse is common, with estimates ranging from 20 to 50% of homeless youth experiencing this form of maltreatment and 40-60% reporting being physically abused (3). Other reasons include parental disapproval of pregnancy, parenting status, sexual orientation, school problems, and drug or alcohol use (5).

Youth who live on the street are at high risk for numerous negative physical and emotional health outcomes. These include malnutrition, sexually transmitted infections,

HIV infection, unwanted pregnancies, drug and alcohol abuse, robbery, sexual and physical assault, and psychological disorders including depression, conduct disorder, and post-traumatic stress. Meeting the basic survival needs of these young people is the highest priority.

School Support

Schools can provide support services and may be the only source of stability in the life of a child or young person who is homeless. The McKinney-Vento Homeless Education Assistance Act requires each public school district to designate a homeless liaison to help identify and assist homeless families, children, and youth. It can be challenging for children and teens that are homeless to get to school, and succeed once they are there. Flexibility in school policies and procedures, provision of emotional support, and linkages to community resources are all important factors that contribute to the possibility of children and youth who are homeless remaining in school and graduating. Schools may consider providing these students with specific HGD and prevention messages tailored to their survival needs, including information about community resources.

For additional information about homeless issues, please see the department's homeless web page at **www.dpi.wi.gov/homeless/index.html**. For additional information and resources about youth who are homeless in Wisconsin, see the Wisconsin Association for Homeless and Runaway Services at **www.wahrs.org**.

References:

1. National Association for the Education of Homeless Children and Youth, National Center for Homeless Education, National Coalition for the Homeless, National Law Center for Homelessness and Poverty, National Network for Youth. (n.d). *McKinney-Vento 2001-law into practice: Who is homeless?,* **www.doe.state.in.us/alted/pdf/whoishomeless.pdf.**

2. R. Nunez. A snapshot of family homelessness across America. Political Science Quarterly, 114(2), 289-307 (1999). **www.familyhomelessness.org/pdf/fact_children.pdf**

3. *America's Homeless Children: New Outcasts, A Public Policy Report for the Better Homes Fund, Copyright 1999*, p.18 and 19.

4. National Alliance to End Homelessness Issue Brief. Runaway and Homeless Youth Act Reauthorization (May, 2003). Retrieved from **www.endhomelessness.org** on 5/25/05.

5. M.J. Robertson & P.A. Toro. Homeless Youth: Research, Intervention, and Policy. Paper from the 1998 National Symposium on Homelessness Research. (1998). Retrieved from **www.aspe.hhs.gov/progsys/homeless/symposium/3-youth.htm** on 5/25/05.

SOURCES FOR LOCAL DATA

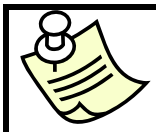
The following table identifies state-level sources and potential community-based data sources associated with adolescent reproductive health objectives.

Healthiest Wisconsin 2010
Health Priority: High Risk Sexual Behaviors

Objective and Indicator	State Sources	Local/County Sources
Decrease in the proportion of Wisconsin high school youth who report ever having sexual intercourse to 30% by the end of 2010.	Department of Public Instruction YRBSS**	Local Department of Health School District
Reduce the percentage of unintended pregnancies among Wisconsin residents to 30% by the end of 2010.	NVSS* State Health Department	Local Health Department
Promote responsible sexual behavior throughout the life span, strengthen community capacity, and increase access to quality services to prevent sexually transmitted infection, including HIV infection.	State Health Department STD Control Programs	Local Health Department

*NVSS – National Vital Statistics System Centers for Disease Control and Prevention
**YRBSS – Youth Risk Behavior Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, CDC

The Wisconsin Department of Public Instruction is offering a confidential online student survey system to assist school districts in gathering data that will yield results that can be used in grant applications, to monitor and plan risk behavior prevention programs aimed a school-aged youth, and to meet evaluation requirements for funders. School districts, at no-charge, can administer on an annual basis the Youth Risk Behavior Survey to middle school and high school students. School districts are responsible for coordinating survey process and administering the survey. Districts that administer the YRBS will receive a slide presentation file (PowerPoint™) providing aggregate frequency tables and graphs, and a dataset that can be used for further analysis and interpretation. For more information on the Online YRBS go to **www.dpi.wi.gov/sspw/oyrbsindex.html**.



Also see: DPI's A Guide to Conducting the Wisconsin Online Youth Risk Behavior Survey (2004) available at **www.dpi.wi.gov/sspw/doc/oyrbsguide.doc.**

In addition, there may be other organizations that have collected local data on youth attitudes, behaviors, health outcomes, and youth development. These include the University of Wisconsin-Extension, United Way, and others. Sometimes local data is based on a convenience sample, and so caution should be used in generalizing from these studies or reports. Anecdotal evidence and qualitative data, such as summaries of youth perceptions collected through focus groups, can be important and useful supplements to quantitative data. In interpreting these data keep in mind they should not be generalized to represent all young people in the community. Nevertheless, they can provide a valuable part of the general profile of young people in the community.

See Resource 3.6 Youth Profile for Our Community Worksheet
See Resource 3.7 Adolescent Sexual Risk Behavior Prevention Needs and Assets Assessment Worksheet

Resource 3.1

Profile of Wisconsin Youth: Key Points 2005

- Thirty-seven percent of students said that it was important for them to delay having sexual intercourse until they were married, engaged, or an adult in a long-term, committed relationship.

- Overall, student reports of risky sexual behavior have decreased significantly between 1993 and 2005.

- The prevalence of high school students who reported having ever had sexual intercourse decreased significantly from 47% in 1993 to 40% in 2005.

- The prevalence of high school students who reported being currently sexually active, defined as having had sexual intercourse in the past three months decreased slightly from 32% in 1993 to 29% in 2005. Twenty-seven percent of male students compared to 32% of female students reported being currently sexually active.

- The percentage of sexually active students reporting using a condom increased from 58% in 1993 to 65% in 2005. Sixty-nine percent of sexually active male students compared to 62% of sexually active female students reporting using a condom the last time they had sex.

- The majority of sexually active students reported using a reliable form of birth control the last time they had sex. Seventy-eight percent of students reported using a condom, birth control pill, or Depo-Provera before their last sexual intercourse.

- About one in four high school students reported using alcohol or drugs before the last time they had intercourse. Male students were significantly more likely to report this behavior than female students (27% compared to 19%, respectively).

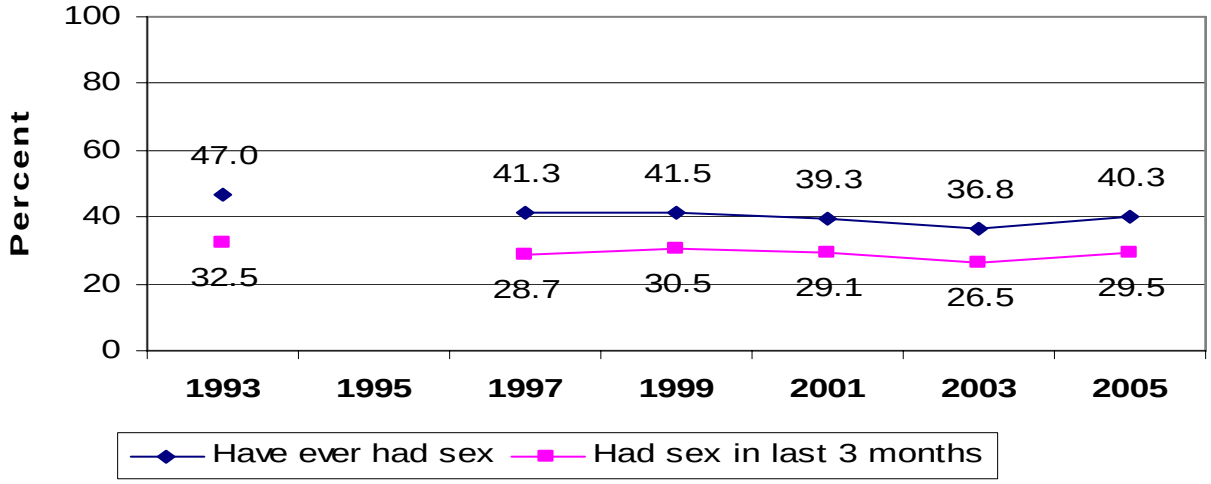
- In Wisconsin (and nationally), the teenage pregnancy rate is down. Since 1988 teen pregnancy rates have declined 24% nationwide and 26% in Wisconsin. (See **www.agi-usa.org/pubs/state_pregnancy_trends.pdf**).

- The pregnancy rates for 1,000 females aged 15-19 in Wisconsin (2000) were 177 for African Americans, 137 for Hispanics, and 39 for Whites. In other words, there was 1 pregnancy for every 5.6 young African American women ages 15-19, 1 pregnancy for every 7.3 young Hispanic women, and 1 pregnancy for every 25.6 young white women.

- STIs represent the largest group of communicable diseases in Wisconsin. About one third of reportable STIs are among persons under 20 years of age.

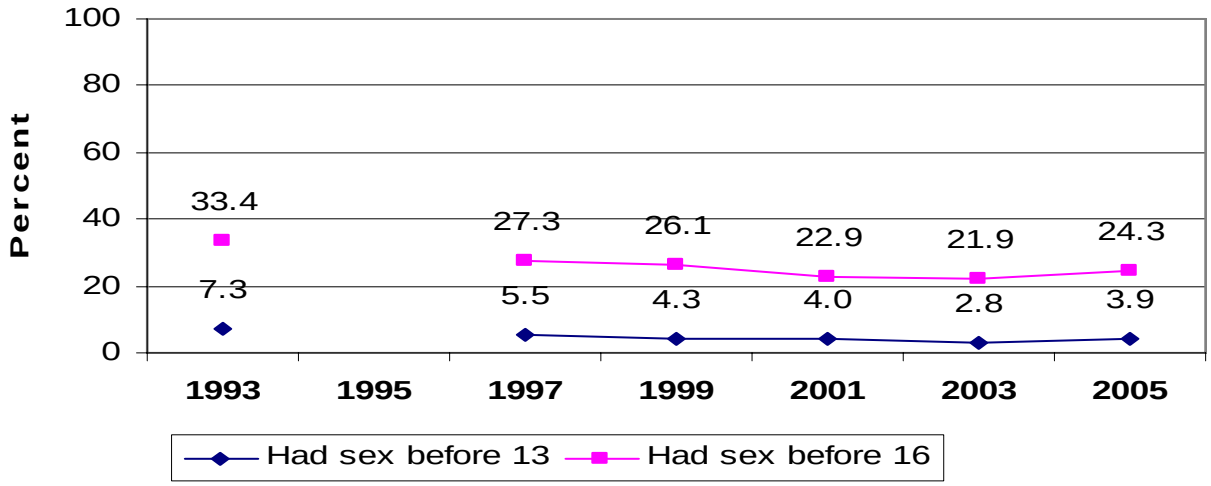
- In Wisconsin 213 adolescents (age 13 to 19) have been diagnosed with HIV infection through December 31, 2004.

Chart 1: Percent of students who have ever had sex or those who have had sex in the last three months. (1993 – 2005)



Data from 1995 unavailable
2005 Wisconsin Youth Risk Behavior Survey *Wisconsin Department of Public Instruction*

Chart 2: Percent of students who have had sex before the age of 13 or 16. (1993 – 2005)



Data from 1995 unavailable
2005 Wisconsin Youth Risk Behavior Survey *Wisconsin Department of Public Instruction*

Resource 3.2

What Do I Know and Not Know About the Sexual Behaviors of Wisconsin Youth?

Questions and answers are based on the 2005 Wisconsin Youth Risk Behavior Survey.

1. What percentage of Wisconsin high school students indicated it was important for them to delay having sexual intercourse until they were married, engaged, or in a long-term committed relationship?

    A. 16%
    B. 27%
    C. 37%
    D. 65%

2. What have been the trends with regard to the percentage of sexually active high school students over the past 10 years?

    A. Slight increase
    B. Significant increase
    C. Remained about the same
    D. Significant decrease

3. Approximately what percentage of Wisconsin high school students reported being currently sexually active (defined as having had sexual intercourse in the previous three months)?

    A. Virtually none
    B. About one-fourth
    C. About half
    D. Most

4. Of high school students who were sexually active, how many reported using a reliable form of birth control (condom, birth control pill, or Depo-Provera) before their last sexual intercourse?

    A. Virtually none
    B. About one-fourth
    C. About half
    D. About three-quarters

5. What have been the trends with regard to condom use among sexually active high school students over the past 10 years?

    A. Slight increase to almost half of sexually active students
    B. Increase to almost two-thirds (2/3) of sexually active students
    C. Dramatic decrease to one-quarter of sexually active students
    D. No significant change.

Resource 3.2, continued

ANSWERS:
What Do I Know and Not Know About the Sexual Behaviors of Wisconsin Youth?

Questions and answers are based on the 2005 Wisconsin Youth Risk Behavior Survey.

1. What percentage of Wisconsin high school students indicated it was important for them to delay having sexual intercourse until they were married, engaged, or in a long-term committed relationship?

   A. 16%
   B. 27%
   C. 37%
   D. 65%

2. What have been the trends with regard to the percentage of sexually active high school students over the past 10 years?

   a. Slight increase
   b. Significant increase
   c. Remained about the same
   d. Significant decrease

3. Approximately what percentage of Wisconsin high school students reported being currently sexually active (defined as having had sexual intercourse in the previous three months)?

   a. Virtually none
   b. About one-fourth, including 27% of males and 32% of females
   c. About half
   d. Most

4. Of high school students who were sexually active, how many reported using a reliable form of birth control (condom, birth control pill, or Depo-Provera) before their last sexual intercourse?

   a. Virtually none
   b. About one-fourth
   c. About half
   d. About three-quarters

5. What have been the trends with regard to condom use among sexually active high school students over the past 10 years?

   a. Slight increase to almost half of sexually active students
   b. Increase to almost two-thirds (2/3) of sexually active students (from 58% in 1993 to 65% in 2005)
   c. Dramatic decrease to one-quarter of sexually active students
   d. No significant change.

Resource 3.3

National Surveys of Adolescent Sexual Attitudes and Behaviors

Youth Risk Behavior Survey (YRBS) – This survey is conducted every two years by the Centers for Disease Control and Prevention to assess risk behaviors of students in grades 9-12.

- Fewer than half of high school students report having had sexual intercourse, reflecting a decline from 53% in 1993 to 47% in 2003.

National Longitudinal Study on Adolescent Health (Add Health) – This is a national survey that examines adolescent health behaviors and other factors that influence their health. The recent survey interviewed 12,118 young people in grades 7 through 12. The recent survey found:

- 17 percent of 7th and 8th graders reported having had sexual intercourse.
- 49% of high school students reported having had sexual intercourse.

National Campaign to Prevent Teen Pregnancy's Fourteen and Younger: The Sexual Behavior of Young Adolescents. This report (2003) is based on three national and three local sets of data to provide important information about younger teens. The report concluded:

- Approximately one in five adolescents has engaged in sexual intercourse before his or her 15th birthday.
- A substantial proportion of teens who are 14 and younger who have had intercourse are not currently sexually active.
- More than one in 10 girls who first had intercourse before age 15 describe it as non-voluntary and many more describe it as relatively unwanted.
- Slightly more than half of 12-14 year old girls and about two-thirds of 12-14 year old boys who reported having had intercourse say they used some form of contraception the most recent time they had sex.

Kaiser Family Foundation's National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes, and Experiences (2003). This is a nationally representative survey of more than 1,800 young people in three age groups: young adolescents ages 13-14, adolescents ages 15-17, and young adults ages 18-24. The survey assessed knowledge and attitudes about sexuality and sexual experience (asked only of participants 15 and older). The survey found:

- 37% of adolescents 15-17 years old reported having had sexual intercourse.
- 80% of young adults ages 18-24 report having had sexual intercourse.

- Of respondents who had engaged in sexual intercourse, a significant percentage had multiple lifetime partners as indicated in the table below:

	15-17 years old	18-24 years old
One lifetime partner	42%	20%
2-5 lifetime partners	39%	39%
6 – 9 lifetime partners	7%	13%
10 or more lifetime partners	4%	14%

- 38% of female participants and 54 % of male participants ages 15 to 17 "strongly agree" or "somewhat agree" that oral sex is not as a big of a deal as sexual intercourse

- More than one-third (36%) of adolescents 15 to 17 (40% of males and 32% of females) reported having had oral sex.

- There were differences in prevalence of oral sex based on ethnicity.
    - 61% of White adolescents and young adults (ages 15-24) reported having had oral sex.
    - 41% of African-American adolescents and young adults reported having had oral sex.
    - 47% of Latino adolescents and young adults reported having had oral sex.
    - 40% of Asian adolescents and young adults reported having had oral sex.

Lesbian and Bisexual Young Women

- A study of 3,816 young women who identify as lesbian, bisexual, or unsure of their sexual orientation concluded that these young women are at an increased risk of pregnancy and poor contraceptive practice. Bisexual and lesbian respondents (33%) were as likely as their heterosexual peers (29%) to have ever had penile-vaginal intercourse.

Reference: SIECUS Fact Sheet: The Truth About Adolescent Sexuality (Fall, 2003)

Attitudes about Having Sex

Seventeen Magazine and the Henry Kaiser Family Foundation conducted a national survey of 510 adolescents ages 12 to 17.

- Reasons for not having sex given by participants ages 15 to 17:

83%	Worried about pregnancy
74%	Conscious decision they had made to wait
73%	Worried about STDs
64%	Worry about what their parents might think
63%	Have not met the right person
63%	Felt they are far too young
52%	Religious beliefs

Attitudes about Relationships and Sexual Activity

Seventeen Magazine and the Henry Kaiser Family Foundation conducted a national survey of 505 adolescents ages 15 to 17. The survey asked respondents about the kinds of sexual activity that might take place in casual relationships or more serious dating relationships. The survey found:

- Activities that are "almost always" or "most of the time" part of a dating relationship or a casual relationship:

	Dating Relationship	Casual Relationship
Kissing	82%	70%
Touching	65%	58%
Oral sex	26%	23%
Sexual intercourse	27%	24%

The National Campaign to Prevent Teen Pregnancy compiled a summary of findings from two nationally representative surveys of 1025 adolescents ages 12 to 17 and found:

- 64% of females and 53% of males said that high school age adolescents should not engage in sexual activity.
- 87% of participants do not think it is embarrassing for adolescents to admit they are virgins.

Knowledge about STDs

The Kaiser Family Foundation's National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experiences is based on a nationally representative sample of more than 1,800 young people ages 13-24. It found that among participants ages 15 to 19:

- 19% do not know STDs can be spread through oral sex
- 60% do not know STDs can cause some kinds of cancer
- 33% do not know STDS can increase the risk for AIDS
- 25% "agree" that if someone they were dating had an STD they would know.

References:

Kaiser Family Foundation. U.S. Teen Sexual Activity (January 2005). Retrieved from **www.kff.org/youthhivstds/3040-02.cfm**

SIECUS. *SIECUS Fact Sheet: The Truth About Adolescent Sexuality* (Fall 2003).

National Campaign to Prevent Teen Pregnancy. *With One Voice 2003: America's Adults and Teens Sound Off About Teen Pregnancy.* Washington, DC: Author (2003).

National Public Radio, the Henry J. Kaiser Family Foundation, and Harvard University's Kennedy School of Government. *Sex Education in America. General Public/Parents Survey* (2004).

Resource 3.4

Youth Development Measures

Youth Development Approach Researchers, Name of Instrument, Website	Features of Instrument
Community Change for Youth Development (CCYD)	
• J.P. Connell, M.A. Gambone • The Youth Survey • **http://www.ppv.org** (Public/Private Ventures)	• includes measures of community support, attitudes, & risk behaviors • appropriate for culturally & socio-economically diverse populations • length of survey requires individual interviews
Communities That Care (CTC)	
• J.D. Hawkins, R. Catalano • The Youth Survey • **http://depts.washington.edu/sdrg** (Social Development Research Group, University of Washington, Seattle)	• focus on adolescents' negative outcomes and their antecedents • measures have high predictive value • appropriate for culturally & socio-economically diverse populations • requires high reading level • must purchase
Resilience	
• B. Bernard et al. • Healthy Kids Resilience Module • (HKRM) • **http://www.wested.org**	• most rigorously tested instrument focusing on resiliency • relatively short, can be used with younger children • appropriate for culturally & socio-economically diverse populations
Search Institute	
• P. Scales, D. Blythe • Profiles of Student Life: Attitudes & Behaviors (PSL/AB) • **http://www.search-institute.org**	• pioneering study, leading first efforts to measure external and internal assets • no published reports of psychometric properties • must purchase

*Although no formal research instrument exists, the Forum has been a leader in the youth development field.
Adapted from Cagampang et al. (2001).
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA (2004).

Resource 3.5

Wisconsin YRBS LGBT Correlation Analysis

Cross-tabulations were used to examine the correlation between those students who reported being threatened or hurt because someone thought they were gay, lesbian, or bisexual and reporting other risk behaviors (e.g., alcohol use, violence). Wisconsin YRBS data from the years 1997, 1999, and 2001 were included in the analysis.

High school students who reported being threatened or hurt because someone thought they were gay, lesbian, or bisexual were significantly more likely to report…

Weapons and Violence:

- Carrying a weapon (gun, knife, or club) in the past 30 days, including on school property.
- Physical fighting and injury from a physical fight.
- Being threatened, injured, or sexually harassed at school.
- Not attending school because they felt unsafe.

Suicide:

- Feelings of depression,
- Seriously considering suicide.
- Attempting suicide.
- Treatment of an injury from a suicide attempt.

Tobacco Use:

- Smoking cigarettes before the age of 13 and in the past 30 days.
- Heavy cigarette use.
- Smokeless tobacco use.

Alcohol Use:

- Alcohol use before the age of 13 and in the past 30 days.
- Binge drinking (5 or more drinks within two hours).

Other Drug Use:

- Using marijuana at least once in lifetime and before the age of 13.
- Using cocaine at least once in lifetime and past 30 days.
- Using inhalants at least once in lifetime and past 30 days.
- Using heroin and methamphetamines at least once in lifetime.
- Being offered/sold/given an illegal drug on school property.

Sexual Behavior:

- Sexual intercourse before the age of 13.
- Used alcohol or drugs before last sexual intercourse.

Source: Wisconsin Department of Public Instruction, Division of Learning Support: Equity and Advocacy, Student Services/Prevention and Wellness Team, 2004.

Resource 3.6

Youth Profile for Our Community Worksheet

Indicator	State Data	Local Data	Local Data Source
Knowledge, Attitudes and Behaviors			
Believe it is important to delay having sexual intercourse			
High school students who have had sexual intercourse			
High school students who are currently (past three months) sexually active			
Sexually active students who use reliable form of birth control			
Sexually active students who use condoms			
Number of sexual partners among high school students			
Alcohol or other drug use among youth			
High school students who identify as gay, lesbian, bisexual or transgender			

Indicator	State Data	Local Data	Local Data Source
Health Outcomes			
Pregnancy rate among teens under age 13-14			
Pregnancy rate among teens age 15-19			
Birth rate			
Abortion rate			
Cases of STIs among youth			
Chlamydia			
Gonorrhea			
Herpes			
Cases of HIV among youth			

Indicator	State Data	Local Data Source	Local Data
Youth Development			
Supportive family			
Supportive adults			
School climate			
Other community supports			
Other youth competencies and assets:			
Internal Assets			
External Assets			

Resource 3.7

Adolescent Sexual Risk Behavior Prevention Needs and Assets Assessment: What Is Needs and Assets Assessment and What are the Key Data Sources? [1]

INTRODUCTION

Needs and assets assessment can be defined as the process of collecting and assessing data that describe the nature and magnitude of both a community's needs, as well as its resources or assets (e.g., financial, organizational, intellectual, institutional, and human), in order to facilitate program planning.

The information collected through needs and assets assessment should describe:
(1) the extent, magnitude, and scope of the problem in the community;
(2) current efforts to address the problem;
(3) gaps in existing services;
(4) local residents' perceptions of the problem, what causes it, and how it might be prevented; and
(5) current (science-based) knowledge about "what works" to prevent youths' sexual risk-taking, pregnancy, and STI/HIV infection.

Needs and assets assessment is an important first step in your program planning process, because it will point toward appropriate (that is, relevant and realistic) goals and objectives for your programming efforts. In addition, depending on the methods used, it can help to inform and interest community members in your prevention or intervention program. It can also provide baseline (pre-program) data that can be used to evaluate your program's progress later on. Finally, needs and assets data are extremely useful as you develop funding proposals and seek to justify to funders why you need the resources that you are requesting.

SOURCES OF DATA

I. Data that are already available
- Census data; City, county, and state vital statistics.
- Survey data on community-wide youth behaviors and experiences (e.g., Youth Risk Behavior Survey).
- Research studies (reports or journal articles) on the prevalence, antecedents and consequences of youth sexual risk-taking, pregnancy, and STI/HIV prevention *nationwide*.
- Research articles describing science-based best practices in preventing youth sexual risk-taking behavior, pregnancy, and STI/HIV infection *nationwide*.

II. Additional data and information that may already be available
- Local needs assessment reports produced by other organizations in your community (e.g., non-profits, government agencies, universities, foundations, private research organizations, or practitioner networks).
- Research studies (reports or journal articles) on the prevalence, antecedents and consequences of youth sexual risk-taking, pregnancy, and STI/HIV prevention *in your local community*.
- Evaluation reports on youth-focused interventions that have been conducted *locally*.

III. New Data Sources that You May Wish to Tap (with Suggested Methods for Data Collection)
- Opinions of key informants or experts from local public and private youth-serving organizations (key informant interviews, focus groups, surveys community forum events).
- Opinions of parents or families of adolescents (focus groups, surveys, community forum events).
- Opinions of youth (focus groups, surveys, community forum events).

[1] The information in this sheet is adapted from: J. J. Card, C. Brindis, J. L. Peterson, & S. Niego. *Guidebook: Evaluating Teen Pregnancy Prevention Programs, 2nd ed.* Sociometrics Corporation Los Altos, CA:. 2001, Chapter 4.

Part 1:

What Should I Collect Information About?

The following information categories should guide your needs and assets assessment data collection efforts. The specific information that you collect should reflect the particular youth reproductive health issue(s) you would like to address, the population(s) you seek to work with, the values of your organization, and the broad prevention approach(es) that you will take (or are considering taking).

I. YOUTH PROFILE

A. General demographic and socioeconomic profile of youth and families in your target community (e.g., gender, ethnicity, age, sexual orientation, income, households below poverty, educational attainment, etc.).

_____

_____

_____

B. Statistics on sexual risk-taking behavior, pregnancies, births, STI, and HIV infection among youth in your community.

_____

_____

_____

C. Statistics on related youth and community issues (e.g., school drop-out rates, alcohol/drug use, gang violence, dating violence, single-parent households, etc.).

_____

_____

_____

D. Youth assets (e.g., positive youth values, interests, and talents).

_____

_____

_____

II. AVAILABLE COMMUNITY RESOURCES SERVING YOUTH

A. Comprehensive health and social services resources (public and private).

_____

_____

_____

B. Family planning services (public and private).

_____

_____

_____

C. School systems resources (e.g., funds to support school-based programs, district coordinator).

_____

_____

D. Youth development efforts (e.g., opportunities for youth to participate in sports, arts, career development activities, tutoring, mentoring, community service, etc.).

_____

_____

_____

E. Concurrent teen pregnancy and youth STI/HIV prevention efforts (local, state, national).

_____

_____

_____

III. COMMUNITY ENVIRONMENT AND NORMS

A. Community attitudes and perceptions regarding youth sexual risk-taking behavior, pregnancy, childbearing, STI, and HIV.

_____

_____

_____

B. Formal and informal policies (in schools, clinics, other organizations, and the media) that create a positive (supportive) or negative (damaging) environment for youth.

_____

_____

_____

C. Funding options and possibilities (including potential sources of money, in-kind contributions, donations of equipment or materials, and volunteers) for your programming efforts.

_____

_____

_____

Part 2:

What Should I Do with My Needs and Assets Data?

It is helpful to use your needs and assets data to develop a brief *problem statement* that offers a succinct summary of the issues, problems, and needs facing a community. The problem statement provides the perspective needed for subsequent program planning activities.

To develop your problem statement, use your needs and assets data as well as your (and your colleagues') prior knowledge about your community to answer the following questions.

1. What is your vision for your community? (Describe your vision or values stance.)

(*Example:* "Our vision is that all youth are entitled to a healthy adolescence—free of pregnancy, STI, and HIV—as well as hope for a bright and productive future.")

_____

_____

_____

_____

2. What is the affected population that you seek to address? (Describe your target population.)

(*Example:* "We seek to target 100 boys and girls per year, ages 14-18, who attend Southside High School in New City. This population is 60% African-American, 30% Latino, and 10% other ethnicities, mainly White.")

_____

_____

_____

_____

3. How significant is the problem? What are the consequences for teens and community members? (Provide evidence for the scope of the problem.)

(*Example:* "In our community, 30% of young women experience a pregnancy by age 18. Among pregnant and parenting teens, the high school dropout rate is four times that of youth who do not become pregnant or parents during their teen years. Teen parents are three times more likely to live below the poverty line households than teens who are not parents.")

_____

_____

_____

_____

4. What causes the problem? (Indicate what key precursors are contributing to the problem based on reliable sources of information (e.g., youth behavior surveys, research studies), and what the gaps are between available and needed services.)

(*Example:* "In our community, teens lack knowledge about the risks of unprotected sex and ways to protect themselves from pregnancy, STI, and HIV. In addition, they lack the communication and negotiation skills needed to decline unwanted sexual advances and to insist upon condom use if they are sexually active. They also do not have strong motivation to avoid teen pregnancy, due to a desire for 'unconditional love' from a child and a perceived lack of other options for the future. Our high school currently lacks in-school or after-school activities that address these gaps in knowledge, skills, and motivation.")

_____

_____

_____

_____

5. How should the problem be addressed? (Summarize potential solutions to the problem, based on scientific research[2] and community perspectives. Include reference to solutions that you will seek to implement.)

(*Example:* "We seek to address the problem through a school-based program that offers teens after-school activities that build the knowledge, skills, and motivation that they need to avoid engaging in sexual risk-taking behavior. This program will include sex education and youth development approaches, and will incorporate characteristics identified in the scientific literature to be common to effective sex education and youth development programs. We will use parent/family outreach and forum activities to build support among parents/families so that they will encourage their youth to attend.)

6. How will we know the problem has been solved? (List one or two key indicators that will provide evidence of program success.)

(*Example:* "Within three years, we will have delayed the average onset of sexual intercourse by one year and achieved a statistically significant increase in use of contraception among program participants.")

_____

_____

_____

_____

[CONTINUED ON NEXT PAGE]

[2] Do not worry about incorporating science-based information on best practices during your initial use of this worksheet if you do not have that information readily at hand. Subsequent Institute activities will help you to further address this aspect of program planning.

Using your responses to items (1-6) above, develop a succinct, two-paragraph *problem statement* that summarizes the issue to be addressed in the community.

4.0 HGD Advisory Committee

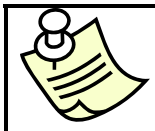
PURPOSE

Wisconsin Statute 118.019 states that school districts that offer human growth and development (HGD) must have an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy and other residents of the school district to develop and review the curriculum at least every three years. In addition to this statutory guidance, the Department of Public Instruction (DPI) encourages parent and community involvement by devoting staff and other agency resources toward these goals.

The implementation of the statutory guidance "to develop and review the curriculum at least every three years" can vary from district to district. The term "develop" can be interpreted in the broad sense of ongoing development and evolution, or it can be interpreted as designing and writing selected lessons or the entire curriculum. In some districts the advisory committee provides leadership in a significant planning process, including conducting a needs assessment of young people, developing detailed educational HGD objectives for K-12 instruction, designing and writing the curricula, presenting the curricula for recommendation to the board of education, and evaluating implementation and outcomes associated with use of the curriculum. In some districts, the advisory committee does not write the curriculum lessons, especially if the school district has a curriculum in place, which is the case for most districts. Feedback, edits, decisions on topics, and timing are all effective ways for a committee to work and develop a curriculum. In other districts, the HGD advisory committee delegates to school staff much of the developmental work, and then reviews curricula, selects curricula with the "best fit," and recommends the curricula to the board of education. In all cases, the HGD advisory committee is a critically important link between the school and the broader community.

CREATING THE HGD ADVISORY COMMITTEE

Wisconsin Statute 118.019 mandates a school district that offers a human growth and development curriculum, the school board shall appoint an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy and other residents of the school district. Remember that this committee should represent a cross section of values and opinions from the community and individuals willing to use a consensus decision-making model. This should increase the likelihood the resulting recommendations to the school board from the committee will be accepted without controversy from school board members and the community.



Also see: DPI's Tools for Comprehensive School Health Programs: Starting a School-Community Health and Safety Council (2001) available at **www.dpi.wi.gov/sspw/pdf/health&safety.pdf** and Running An Effective Meeting (2001) available at **www.dpi.wi.gov/sspw/pdf/effectivemeeting.pdf**.

RECRUITMENT

Wisconsin Statute 118.019 addresses the HGD advisory committee (see Section 2 of this Resource packet). There are a variety of ways to recruit members for the HGD advisory committee. Regardless of whether the approach includes informal or formal invitations to apply for membership or school board invitations to serve, it is important that prospective members understand the charge to the committee and the time commitment expected of committee members. Some form of written application is useful as it provides documentation of prospective committee members' expertise or perspective. Members of the HGD advisory committee should include parents with children currently attending the district's schools, teachers, school administrators, pupils, health care professionals, members of the clergy, and other residents reflecting the community's racial and ethnic composition. The HGD advisory committee could include both a male and female student, and the students' parents/guardians will need to approve of the student's participation. Selection of advisory committee members and the committee's role and responsibilities needs to be made by the school board.

Suggested requirements for HGD advisory committee membership include:

- Willingness to serve, and the ability to make the time commitment (ideally for at least two years).
- Effective communication skills, including listening well, and speaking in an understandable manner, especially at public meetings when emotions run high.
- The ability to be objective and open to others' ideas when making decisions and recommendations.
- The ability to control one's emotions, even when holding strong opinions about sexuality education.
- Being viewed as a respected representative of the community.
- A commitment to young people and the school's educational mission.

Adapted from American School Health Association *Sexuality Education Within Comprehensive School Health Education, 2nd edition*. (2003).

For an example of ways in which HGD advisory committee recruitment can occur see **Resource 4.1, HGD Advisory Committee: Oconomowoc**.

GROUP PROCESS

The HGD advisory committee chairperson should be a skillful group facilitator who is respected by members of the advisory committee and the community. This individual

will be expected to conduct effective meetings of the HGD advisory committee, facilitate public meetings, make presentations to the school board, and possibly interact with the press.

Best practices suggest it is helpful for HGD advisory committee members to establish ground rules to guide their meetings. The combination of guidelines should help to create a meeting environment in which ideas are shared, individuals are respected, there is a commitment to consensus, and a group norm for effective use of meeting time.

See Resource 4.2 HGD Advisory Committee Ground Rules: Eau Claire Area School District

An agenda distributed before the meeting is useful to encourage preparation for the meeting and to help facilitate focused discussion and decisions. Meeting frequency varies, and is a function of the magnitude of the tasks at hand and the time frame in which recommendations must be made. In general, momentum diminishes when too much time passes between meetings but sufficient time is needed between meetings to accomplish the "leg work" and other tasks needed to move the planning process along. Stoughton Area School District's HGD advisory committee sent a letter to all committee members detailing the group's purpose and the meeting schedule to complete the review of the HGD curriculum.

See Resource 4.3 Example of HGD Advisory Committee Purpose and Meeting Schedule: Stoughton Area School District

See Resource 4.4 10 Tips for Meeting Facilitation.

It is important to develop and distribute meeting notes. The degree of detail will vary but in general the record of the meeting should include attendance, key discussion points, and most important, a record of decisions made by the committee.

Another initial task of the HGD advisory committee is to develop a policy and approach to address potentially controversial issues. The National School Boards Association provides guidance for this. Anticipating potential controversy, and being prepared with clear policies and opportunities for communication are keys to working with challenging issues.

See Resource 4.5 Controversy and Pressure Groups (National School Boards Association)

GETTING DOWN TO WORK

Best practices also suggest it is helpful for HGD advisory committee members to identify the steps and process necessary to accomplish its charge. In general this includes understanding the current situation (e.g., risk behaviors, assets) and desired short-term and longer-term impacts, identifying resources, planning and developing activities, and documenting outcomes or goals. The logic model provided below illustrates as a linear

flow chart the rationale for a HGD program and the program planning process. It is important to remember that in practice the planning process steps may not be as discrete or linear as presented here.

HGD Program Planning Logic Model

Current Situation	**Resources**	**Activities**	**Short-term outcomes** (knowledge, attitudes, intentions)	**Longer-term impacts**
What is the health status of children, adolescents, and young adults in our community?	What do state statutes say school districts can and cannot do related to HGD? What is the role and responsibilities of the HGD advisory committee? What support do teachers need to provide effective HGD instruction?	How can the school support parents in their role as primary sexuality educators of their children? What HGD curriculum is most likely to be effective and acceptable in our community? What HGD curriculum is most likely to promote healthy behaviors and preventing risky behaviors?	What do our students know and what can they do as a result of HGD instruction? To what extent does youth behavior promote health or reflect health risks?	What is the health status of children, adolescents, and young adults in our community?

1. Describe Current Situation and Identify Desired Short-term Outcomes and Longer-term Impacts

Describing the current context in which young people are developing, and articulating the desired knowledge, behaviors, and health outcomes of young people provides a foundation for HGD program development. This stage includes developing or reviewing background information about young people in the state and district, including trends in sexual risk behaviors such as information included in the Profile of Wisconsin Youth section of this resource packet.

2. Identify Available Resources and Statutory Guidance

Identify available school district and community resources, as well as HGD statutes (see Section 2) that are integral for developing a HGD program. What support will HGD teachers need to provide effective instruction?

3. Plan HGD Program Activities

There are many components to this important step in the planning process.

a.) ***Develop Position Statement***. As a foundation for the actual curriculum development and planning, it is useful for the HGD advisory committee to develop a position statement or belief statement about sexuality education in the district. Two examples are provided below.

Sample Belief Statement (American School Health Association, 2003, p. 10)

- Parents are the primary teachers of sexuality education and the best place for discussion to provide the values and religious preferences of the family is in the home. Schools need to instruct curriculum in a manner that encourages communication between students and parents.
- Every decision has positive or negative outcomes, some of which can result in serious consequences. For students to make responsible decisions regarding sexuality, they need accurate information, respect for others, and a framework of values.
- Abstinence prior to marriage is the healthiest choice for physical, emotional, social, and spiritual well-being.
- Sexuality is a natural and healthy part of living.
- Sexual relationships should never be coercive or exploitative.
- Sexuality education is a lifelong process that begins in the home and family.
- Sexuality education includes formal education programs as well as the informal learning that comes from the influence of peer groups, cultural heritage, messages of the media, advertising, religious teachings, and daily exposure to custom and changing technologies.

Sample HGD Mission Statement (Grades K-12): Stoughton Area School District (2005)

> Human Growth and Development is one part of the district's health curriculum.
>
> Stoughton's human growth and development curriculum is based on abstinence* and is designed to help students
> 1.) understand their growth, development, and sexuality,
> 2.) develop a positive self-concept, and
> 3.) acquire factual knowledge, skills, attitudes and values that result in behavior that contributes to the well-being of the individual in connection with their family as they develop strategies for responsible decision-making.
>
> *A human growth and development curriculum based on abstinence emphasizes the value of abstinence but also includes information on contraceptives at specified grade levels.

b.) ***Develop Statement of Implementation Guidelines***. A related document is a Statement of Implementation Guidelines to identify and describe decisions and approaches upon which the HGD program is based. This written document serves as a summary statement about the HGD program for administrators, school staff involved in HGD instruction, and other interested parents and community members.

See Resource 4.6 Milwaukee Public Schools HGD Implementation Guidelines

c.) ***Identify Topics for Inclusion in Curriculum***. As the HGD advisory committee begins the process of determining what topics should be addressed at what grade level in their particular district, they may wish to survey or hold focus groups with parents and/or students. Both formal and informal surveys can provide guidance on ways in which parents would like the school to support them in their role as primary sexuality educators of their children.

See Resource 4.7: The Milwaukee Public Schools Parent Survey is an example of an instrument used to obtain parental input in the planning process.

d.) ***Adopt Curriculum Review Criteria***. Before the HGD advisory committee begins the process of reviewing curricula, it is helpful for committee members to adopt curriculum review criteria to guide discussion and decisions about curricula to be used in the district. Suggested curriculum review criteria are provided in the Effective HGD Curriculum and Instruction section. Some school districts include HGD instruction as part of comprehensive school health education and others address HGD as a discrete unit of instruction. In either case, the HGD advisory committee may be reviewing packaged curriculum, curriculum developed locally, or some combination. More guidance and resources for this critical step are included in Section 6 of this resource packet.

e.) ***Review curriculum or develop curriculum***. When developing a curriculum it is important to consider the background, skills, and knowledge of those responsible for writing the curriculum. Usually the primary curriculum writers are the content specialists within the district, which would include teachers and curriculum coordinators who have formal professional preparation in curriculum, instruction and student assessment. The level of involvement in the actual writing of new or revised lessons can vary greatly among advisory committees because the professional expertise of advisory committees can also vary greatly. Delegation of the writing responsibilities is a decision to be made by the school district.

f.) ***Obtain additional feedback***. The HGD advisory committee may present the proposed recommendation to the community and parents for additional feedback prior to making its recommendation to the school board for approval. Community support is a critical component for sexuality education in the schools and the time and energy required to develop and maintain positive public relations is a sound investment.

g.) ***Make recommendation***. The HGD advisory committee recommends adoption of a HGD curriculum to the school board which has ultimate responsibility for curriculum adoption. Usually the HGD advisory committee chairperson makes a verbal and written presentation to the school board and members of the advisory committee respond to questions.

h.) ***Continue communication about the HGD program***. Throughout the process (as well as after a decision to adopt a particular HGD curriculum has been made) it is important to communicate with parents and to keep the school board apprised of progress. Even after decisions have been made about the curriculum, HGD advisory committee members may continue to be involved in fostering communication about the curriculum. For example, members of the HGD committee could participate in the process by which parents have the opportunity to review the instructional materials. Hearing parental reactions, support, and concerns provides an informal way in which an on-going needs assessment can be conducted. Sometimes parental objections to the curriculum may occur because parents have not had an opportunity to thoroughly review and discuss the curriculum. A respectful exchange where parents are comfortable sharing their concerns and the local school district has an opportunity to explain why they think this is an important curricular area and the basis for decisions about curricular content will enhance the likelihood of parent acceptance of the curriculum. There are numerous ways to foster communication with parents and specific strategies are discussed in Section 5 of this resource packet.

i.) ***Support staff development***. Following selection of a curriculum, it will be important to provide staff development opportunities for teachers who will be involved in teaching human sexuality. See Section 7 of the resource packet for more discussion on this topic.

SHORT-TERM OUTCOMES AND LONGER TERM IMPACTS

The HGD advisory committee can recommend that data be collected about the knowledge, attitudes, and skills students develop as a result of the HGD curriculum. In addition to monitoring these short-term outcomes, the advisory committee can update the profile of the health status of children and youth in the community to assure that the HGD curriculum is addressing the needs of youth. In this way not only is there information about the effectiveness of the HGD curriculum and instruction, but also an on-going needs assessment to guide future review and revision of the HGD curriculum for the district.

Also see DPI's Health Literacy Performance Assessments CD: 2004-2005 Edition. Included on the CD are performance assessments for Alcohol & Other Drug Use Prevention, Character Education, Community Health, Consumer Health, Driver Impairment, Environmental Health, Food Safety, HIV/AIDS Prevention, Mental & Emotional Health, Nutrition & Dietary Behavior, Personal Health, Physical Activity Promotion, Sexuality & Family Living, Suicide Prevention, Sample Unit on Suicide Prevention, Tobacco Use Prevention, Unintentional & Intentional Injury Prevention, Appendix. The CD is available from the DPI Student Services/Prevention & Wellness team and can be ordered by calling 608-266-8960 or send an email request to jackie.brashi@dpi.state.wi.us.

References:

Sexuality Education Within Comprehensive School Health Education. 2nd edition. American School Health Association. Kent, Ohio. 2003.

Resource 4.1

HGD Advisory Committee: Oconomowoc

Human Growth and Development Committee Background Information from the Oconomowoc School District

According to state statute, our school board appointed a 22-member community advisory committee to develop a human growth and development curriculum. In order to follow state statutes and to ensure that our community is well represented on the committee, the school district health coordinator:

1. Contacted the PTO/PTA organizations at each of the district's schools and asked them to provide a committee member from their school who would report back to those parents.

2. Contacted the Ministerial Association and asked them to provide a committee member from the clergy.

3. Sent notices out to all elementary teachers to ask for representatives from each grade level.

4. Requested that the health teachers from middle and high school participate on the committee.

5. Contacted district student services and asked that at least one guidance counselor participate on the committee.

6. Contacted district administrative council and requested representation.

7. Requested that the district nurse be on the committee.

8. Contacted the local medical association and asked them to provide a health care professional for the committee.

9. Contacted the high school student services and asked them to provide a list of students (juniors or seniors) who would be candidates for committee membership. Those students were then contacted for committee membership.

10. Contacted local papers to "notice" the formation of this committee and to ask anyone interested to contact the superintendent for committee membership.

This committee developed the objectives for the curriculum and the grade levels at which the objectives should be covered. The meetings were publicly noticed and time was allotted at each meeting for public input.

The school board adopted the curriculum as presented and directed the health coordinator to implement the objectives. Local teachers from each grade level met and developed the actual lessons and materials needed for each grade.

Resource 4.2

Human Growth and Development Advisory Committee
Ground Rules: Eau Claire Area School District

1. One speaker at a time.
2. Confidentiality.
3. Silence equals consent.
4. Address the issue not the person.
5. Respect/honor others' opinions.
6. Disagree without being disagreeable.
7. Members who leave the committee can be replaced.
8. Time limits are set for meetings (two hours maximum).

Resource 4.3

Example of HGD Advisory Committee Purpose and Meeting Schedule:
Stoughton Area School District

Committee Purpose:

(1) Review the present human growth and development grade level objectives and make recommendations for changes. Grade level objectives address (a) issues surrounding sexuality to include physical/emotional changes, sexual intercourse, birth control, pregnancy, and childbirth, (b) communicable diseases including sexually transmitted diseases, and (c) protective behaviors including prevention of sexual abuse.
(2) Review parent notification procedures and make recommendations for changes.
(3) Draft recommendations to be presented to the School Board.

Meeting Schedule:

Tuesday, May 18, 4:00 – 5:30 pm

- Time for public comment
- Time for questions/discussion regarding prior material distributed
- Review, discuss, reach consensus
    - Mission statement
    - Partnerships with parents/guardians
    - K-3 guidelines
    - 4-12 guidelines
- If time permits, begin grade level objective review

Thursday, June 3, 4:00 – 5:30 pm

- Time for public comment
- Review, discuss, reach consensus on K-12 grade level objectives (Work in 4 groups: K-3, 4-6, 7-8, high school – consensus will be reached first in small groups and the K-12 discussion will occur and consensus will again be reached.)

Tuesday, June 15, 4:00 – 6:00 pm

- Time for public comment
- Review, discuss, consensus on parent exemption from Human Growth & Development
- Plan for Board presentation

Tuesday, June 29, 4:30 – 6:00 p.m.

- Remaining business

Resource 4.4

10 Tips for Meeting Facilitation

1. Be clear about the purpose of the meeting and set an agenda based on the purpose.

- To inform – to get or give information.
- To form – to make a decision or to solve a problem.
- To perform – to complete a task.
- To conform – to maintain a routine.

2. Be prepared.

3. Start and end meeting on time.

4. Establish group guidelines or working agreements for how the meeting will function.

5. Assign procedural tasks (e.g., recorder, timekeeper).

6. Facilitate discussion, and as the facilitator, maintain neutrality.

7. Make decisions, recommendations and/or assign tasks.

8. Refer tasks to committees when appropriate.

9. Bring closure to the meeting.
   - Summarize without introducing new ideas.
   - Schedule next meeting.

10. Follow-up with substantive and procedural tasks (e.g., distribution of minutes via mail or email).

Adapted from:

Anderson K. *The Busy Manager's Guide to Successful Meetings*.
GLSEN. *The GLSEN Jump-Start. A How-to Guide for New and Established GSAs*

Resource 4.5

Controversy and Pressure Groups

Source: National School Boards Association. **Issue Brief**, Number 11, March 15, 1993

ISSUE BRIEF NUMBER 11****ISSUE BRIEF NUMBER 11*****ISSUE BRIEF NUMBER 11

One of the many strengths of a comprehensive school health program is that it treats the health risks facing our students in a holistic manner. A comprehensive program addresses issues that may stir controversy in our communities, such as a facts-based approach to sex and HIV/AIDS education and school-based health services. Managing controversy is one of the most difficult and critical aspects of implementing a truly effective program; however, a health program that does not honestly address controversial issues in an age- and culturally-appropriate manner is, at best, ineffectual in helping children make appropriate choices and avoid risky behaviors.

Concerns about various components of your district's school health program can arise both from within your community and from organized groups based outside your district. While we as school representatives welcome, even thrive on, the diversity of our society–whether political, religious, or cultural–and welcome discussion from all, eventually someone has to make the final decision regarding the context and the content of your programs. When disagreements about what should be included arise, local citizens generally will be more responsive to negotiation and problem-solving within the confines of the school setting. Statewide or national organizations tend to have an agenda, which transcends district interests, and, so, are less likely to be open to negotiation. Remember, the best defense to challenges is a good offense. It is important to have the appropriate policies in place prior to controversy. Good policy on curriculum selection and instructional materials development will help you outline a strategy for dealing with challenges to board decisions. Make sure you have considered the following:

An up-to-date policy on selection of curriculum and materials, and program planning. Make sure your policy is well defined and accessible to the public.

- Having a citizens' advisory committee to aid this process will help build a coalition of advocates for the curriculum. If you choose to convene a committee, make sure it has a wide range of representation and includes professional curriculum experts and persons knowledgeable in health topics.
- Providing a period for written public comment on the proposed curriculum and program plan can alert you to the attitudes of special interest groups in the community and may give you advance warning of organized opposition to your program components.
- Having the materials available for public viewing at the school district office, the public library, or some other equally accessible place will serve a two-fold purpose; giving those truly interested a chance to be involved in the process, and providing a response to later challenges that citizens were unaware of the contents of the curriculum or materials.

A policy regarding complaints and/or reconsideration of existing curricula, instructional materials or program procedures.

- This may be your most potent weapon against attacks on existing components. If you choose to create this policy, make sure it is very specific about the way challenges are to be brought. Many districts, which have survived pressure group tactics, have said that time was their most effective ally. An established process very often has the effect of dissipating a bandwagon mentality. Making opponents adhere to a strict code of behavior as outlined in a policy, allows the board and the superintendent to keep control of volatile situations.
- If an unexpected challenge should arise at public board meetings, make sure everyone follows the procedural rules for that meeting. Do not allow people to speak out of turn, yell, exceed the time limit, or bring any type of voice enhancement devices (e.g. microphones or megaphones), and make sure both challengers and defenders get equal access to floor time.
- When first confronting these challenges it is important to listen and not become defensive. Assess the situation; find out more about the challenge, discuss the issue among the board after you have all the facts and, then, begin the process of resolving the controversy. If you appear unreasonable or dogmatic at the outset, you may galvanize resistance among community members who have not yet made up their minds.

Bear in mind that all groups have a constitutional right to be heard, and that there are times when material in the curriculum should be removed. Not all challenges are negative in nature. When your school board decisions are challenged by groups, the following recommendations from school board members who have been "through the mill" may be helpful:

- Be prepared by keeping abreast of which organizations are making challenges in your state. Periodic monitoring of newspaper editorial columns and metro pages may alert you to the presence of organizations moving into your area. Keep in touch with board members and superintendents of nearby districts. If you are the subject of a challenge, make sure neighboring districts know about it so that they can prepare themselves for similar disputes. Knowledge about organizations that make it their business to challenge school curricula and operations can be critical.
- Research the challenging organization's tactics carefully. Some use legal jargon to confuse and disrupt meetings, often incorrectly quoting from state or local guidelines as a basis for the challenge and sometimes using blatant misrepresentation of facts.
- Don't allow a group to "divide and conquer" the board members. Remember you are a team and you have approved these programs as a team. Designate a representative from the board or the superintendent to field all questions on the subject under debate. If citizens attempt to contact other board members, agree that each of you will make no comment on the subject and will refer all questions to the designated spokesperson.
- Remember, when conflict arises, it affects everyone from the school board members and superintendent to the classroom teachers and students. Keep your teachers, librarians, administrative staff and classroom volunteers informed about your support for these programs and your desire for everyone to continue "business as usual," or advise them of your reasons for changing positions.

Community involvement and support are critical in defending against group challenges. Be prepared by knowing your strengths and using them to your best advantage. Know and cultivate your allies.

- Opponents will come looking for you, so it's your job to go looking for community support before controversy arises. If you have included local citizens in the curriculum selection process, it is likely that your decision is in sync with the community. Therefore, pressure groups are subverting the process; it is then, your responsibility to protect the interests of the larger community and it is their responsibility to help you.
- Ask the heads of community organizations for their support if challenges should arise.
- Establish a citizens' advisory committee to review new curriculum and programs and do not forget to include local media representatives on your committee. Newspaper, television and radio personnel not only report on what is happening, they are also citizens who live, vote, and send their children to school in the community.

You will not be able to stop the challenges, nor should you want to do so. You do want to ensure that you have a strong curriculum selection, program planning and review policy that provides for appropriate response to legitimate concerns. These policies, along with community involvement in your schools and a school board committed to the process, can provide your best defense. Remember, you have chosen these program components with the best interests of your students and your community in mind and are making a good faith effort to protect those charged to you from making unhealthy and risky decisions. You have a right and a responsibility to give them the most comprehensive program you can.

For more information contact:

School Health Programs
National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722
info@nsba.org

Resource 4.6

Milwaukee Public Schools HGD Implementation Guidelines

Principals should be aware that:

- The person responsible for the program in each school is the principal.
- It is the responsibility of the principal to provide coordination for the program to assure vertical and horizontal articulation as well as appropriate planning, implementation, and evaluation of the program within his or her school.
- The teachers of the program must be regular teachers in the schools.
- An integral part of the kindergarten through grade 12 Human Growth and Development program is teacher inservice education. The inservice education program should instruct teachers in the scope and sequence of the K-12 program. This will provide a logical continuity of sequencing on which more advanced concepts can be taught at higher grade levels. Encourage teachers to participate in this inservice.
- It is expected that all teachers will be provided the necessary preparation to implement the program in their classrooms. However, when for good reason, a teacher is unwilling or unable to teach the content, the principal has the responsibility to make appropriate adjustments.
- The parents play the most important role in this educational process. The parents are to be invited to attend meetings to have the curriculum explained. Initial implementation meetings for elementary schools, middle schools, and high schools are to be held on separate dates (in either the day or the evening) in case a parent has children in more than one school. Background material in the introductory section of this curriculum can be shared with parents to assist them in their primary role of sexuality educator for their children.

Teachers and Principals should be aware that:

- A student may be excused from the Human Growth and Development program upon written parental request to the classroom teacher or principal.
- The classroom teacher/s will be responsible for coordinating the Human Growth and Development unit. The classroom teacher/s may utilize the strengths of other teachers and resource persons available to the school in a team-teaching approach.
- Teachers of Human Growth and Development should possess:
    - A willingness to learn as well as to teach.
    - A readiness to admit ignorance or discomfort.
    - Sensitivity to individual differences and comfort levels.
    - A commitment to freedom of speech and diversity of values.
    - A belief that one of the important goals of education is to help people think clearly.
    - A good dose of natural humor.

- Teachers shall follow the accepted scope and sequence to insure that basic attitudes and concepts are reinforced and developed further at advance levels of instruction. This also provides parents with the expectations and concepts to be taught at the respective grade levels.

- The curriculum may be modified as necessary for the exceptional education student. Such modifications may utilize programs already in existence as guidelines in writing curriculum.

- Teachers are expected to select methods of teaching that are appropriate to the developmental levels of their students and to the content areas being studied.

- Certain topics (self-control, self-respect, self-esteem, chastity, celibacy, abstinence, sexual intercourse, birth control, homosexuality, masturbation, abortion) are to be addressed in the programs in a factual manner, allowing parents to teach in the home their personal, moral, ethical, and religious convictions on these subjects. Parents and community will be informed regarding which grade levels the topics will be taught.

- Whereas, actions involving sexual intercourse, birth control, abortion, abuse, sexual assault, and alternative lifestyles have become issues of legislative and judicial procedure, the current legal implications will be taught at appropriate grade level.

- When students come to teachers with personal problems regarding sex, the teachers answer the questions factually as far as their training qualifies them to do and give such guidance as seems appropriate for understanding the wholesome decision making on the part of the students. At all times, teachers refer students to their parents as the first source of guidance.

- All resources brought from outside the school need to be reviewed by appropriate staff/committee before utilizing the resources in a classroom presentation.

- The classroom teacher/s shall have the cooperation of the health and physical education specialist, staff members of the supportive services and other persons interested in the unit to assist them with specific lessons and/or units in the Human Growth and Development curriculum.

- In addition to meetings, parents will be made aware of the curriculum by one or more of the following:

    - MPS INFO (parent information bulletin).
    - A single brochure and/or mailing.
    - An announcement made by principals of schools.
    - An invitation by school principals for parents to come to school and review curriculum.
    - Parent involved school organizations.

Teachers – may wish to consider the following suggestions when implementing this curriculum:

- Teachers have the primary responsibility for developing an appropriate atmosphere or emotional climate in the classroom.

- Become familiar enough with materials to be comfortable with them.

- Establish rules – the right to be heard and the importance of respecting each other's opinions and feelings.

- Avoid separating males and females except for specifically recommended areas. They need practice talking together. Avoid separating, except to fill gaps in their knowledge about their own sex that they don't want to discuss with the opposite sex.

- Do not assume knowledge or understanding of words (street or scientific language).

- Use correct terminology and correct spelling. When street language comes up use it as an opportunity for learning correct terms. This might mean that students also have to learn meaning of the word slang to help differentiate between the two categories of words.

- The role of the teacher is to present information, stimulate discussion, to correct misconceptions and answer relevant and appropriate questions others can't answer.

- Answer student's questions simply and factually. If you don't know an answer, say so and tell students you will look it up and tell them next time – and then do that. Encourage students also to look up and seek answers to such questions.

- Rephrase a question to a level of mutual comfort for all members present.

- Do not assume anyone knows everything. It is difficult for people to admit that they don't know everything about themselves and issues related to sexuality. For example, saying "you probably already know this, but…."

- Avoid answering individual questions for which all pertinent information is not available. For example, if an individual student asks "If I have a catheter can I still father children?" tell him this is something to discuss with his own doctor because of medical information about his own condition that is necessary to provide an exact response.

- Start where the group is. Have the participants, to some extent; select their own discussion topics. Distribute cards and ask students to write questions on topics they want to discuss. Discussion should not center on specific personal problems unless almost everyone in the group shares the same problem.

- Refer certain types of parent requests to the administrator in charge. This individual is in a better position to be aware of the entire situation – such things as previewing materials and visiting classes, require preparation on the part of the school to meet needs of parents most effectively.

- Because limited knowledge is often one characteristic of individuals making unhealthy decisions, it is often necessary to teach about topics a teacher does not necessarily wish students to participate in immediately. The teacher should take care that students are made aware of appropriate/healthy and inappropriate/unhealthy behaviors and situations in their environments.

Resource 4.7

MPS Parent Survey about Scope and Sequence of HGD Topics

Dear Human Growth and Development Advisory Board Members,

Please work with 5-10 parents who have children in the MPS schools. Do not simply hand this to them. We would like you to talk with them about the survey. Listen to their concerns and questions. Make note of them. Tell them about this process of revising the curriculum and our desire to listen to their ideas and concerns. Let them know that we will be looking at our children in Milwaukee. We will consider what kids and families need. We will look at the information about what sexual behavior our kids are choosing and what seems to be working to help kids make wise choices for their health.

This fall there will be an opportunity for them to review what this committee has done prior to it being offered to the students. If they would like direct notice of this opportunity, please get their address. Otherwise, this can remain an anonymous survey.

To complete the survey, use only the page titled Scope and Sequence. Ask the parent to put an "I" in the box of the grade level that they feel would be best to introduce the concept to children. The definitions page is to help you explain some of the categories and the range of information that the topic covers. Explain that even though a topic is introduced, it is not thoroughly covered at that grade and will be built upon as the students mature and progress through the following grades. They can put any comments in the comment line to clarify what they would like to see taught. (Don't be surprised if there are not many in the K-1 column.)

This is not meant to be an exact science. We mostly want to engage you and parents from MPS in dialogue that will help us to do our work in the context of the community we are serving.

Please FAX the responses to XXX or mail to XXX.

Thank-you for this important input to the Advisory Board.

Scope and Sequence for Human Growth and Development K-12

	K-1	2-3	4	5	6	7-8	H.S.	Never	Comments
Human Development Reproductive anatomy and physiology									
Reproduction									
Puberty									
Body image									
Sexual identity and orientation									
Other									
Relationships Families									
Friendship									
Dating									
Marriage and lifetime commitments									
Adoption									
Raising children									
Other									
Personal Skills Values									
Decision-making									
Communication									
Assertiveness									
Negotiation									
Looking for help									
Other									
Sexual behavior Sexuality throughout life									
Masturbation									
Shared sexual behavior									
Abstinence									
Human sexual response									
Sexual dysfunction									
Other									
Sexual Health Contraception									
Pregnancy Options									
Sexually transmitted diseases, HIV Infection									
Sexual abuse									
Reproductive health									
Other									
Society and Culture Gender roles									
Sexuality and the law									
Sexuality and religion									
Cultural Diversity									
Sexuality and the media									
Other									

I = introduce concept

Some Helpful Clarifications

Human Development
Reproductive anatomy and physiology – From parts "covered by swimsuit" to specific organs/functions in later years
Reproduction – From "all life reproduces" to human intercourse in later years
Puberty – changes adolescents go through
Body image – how students feel about their bodies and the impact of this on health behaviors
Sexual identity and orientation –Variety in expression of maleness and femaleness to sexual orientation in later years
Other
Relationships
Families
Friendship
Dating
Marriage and lifetime commitments
Adoption
Raising children
Other
Personal Skills
Values
Decision-making
Communication
Assertiveness
Negotiation
Looking for help
Other
Sexual behavior
Sexuality throughout life – how sexuality is intertwined throughout a person's life
Masturbation – self pleasing to safe sex alternative
Shared sexual behavior – range of behavior for consensual activity along with the potential health risks
Abstinence
Human sexual response – natural urges and responses to stimulus
Sexual dysfunction – natural– fluctuations during lifetime to physical conditions that limit function
Other
Sexual Health
Contraception – various options with risks and benefits
Unwanted Pregnancy Options- adoption, abortion
Sexually transmitted diseases, HIV Infection
Sexual abuse
Reproductive health – routine health exams during and beyond puberty
Other
Society and Culture
Gender roles – stereotypes to current roles in families
Sexuality and the law – what is unlawful sexual behavior (adult-child, teen-teen, etc.)
Sexuality and religion
Cultural Diversity – understanding different attitudes around sexuality
Sexuality and the media – how sex is portrayed in the media and how media influences sexual attitudes and conduct

5.0 Parental Communication

Parents are the first and primary sexuality educators of their children. Communication is critical for parents/guardians and school staff to complement each others' efforts in providing high quality and developmentally appropriate human growth and development (HGD) instruction for children and youth. Schools can support parents by providing opportunities and resources to increase parents' knowledge, skills, and confidence in their important role as sexuality educators of their children, and clearly the experts in sharing their family's values. Schools can use a variety of strategies as noted below to increase parents' familiarity with the school-based HGD curriculum and instruction.

COMMUNICATING WITH PARENTS ABOUT THE HGD PROGRAM

- Invite parents to a HGD information meeting. Provide at least two convenient opportunities for parents and guardians to meet the HGD teachers, preview HGD curricular materials and have their questions about the instruction answered. It is helpful for one of these meetings to be scheduled in the morning or early afternoon to accommodate parents who work in the evenings. It may also be helpful to hold one of the meetings out of the school and in a community setting where some parents may be more likely to attend. Send invitations in languages family members can read. Publicize the meeting in community newspapers. Phone or e-mail parents to remind them of the meeting. Provide food and beverages for the parent meeting. Arrange for childcare to be available. Provide transportation for parents/guardians to attend the meeting.

  (See Resource 5.1 for an example of a HGD Parent Information meeting agenda.)

- Distribute a handbook to inform parents about the district's HGD unit of instruction

- Disseminate a grade-level brochure describing available HGD library materials.

- Provide written information about the HGD program in languages used by students' parents (e.g., Spanish, Hmong).

- Provide information about the HGD program on the local access cable channel and distribute a letter to parents making them aware of this viewing opportunity.

- Distribute newsletters with information about the HGD program.

OPT-OUT OPTION

State law maintains that parents have the option to exempt their children from HGD instruction. This is called the "opt-out" option. Wisconsin statutes do not provide, and legislative history does not support, the use of the parental "opt in" method by local school districts in which parents give consent for their children to participate where the "opt out" method is statutorily specified. The opt-in method would require a parent to notify their child's principal/teacher if they want their child to take instruction in HGD.

In general, few parents do not want their children to participate in HGD instruction. Parental objections may occur because parents have not had an opportunity to thoroughly review and discuss the curriculum. A respectful exchange where parents are comfortable sharing their concerns and the local school district has an opportunity to explain why they think this is an important curricular area will enhance the likelihood of parent acceptance of the curriculum. Frequently when parents are given the opportunity to learn more about the HGD curriculum, review the materials, and have their questions answered, their reservations and concerns are alleviated.

In a situation where a parent continues to object to their child participating in instruction on physiology and hygiene, AIDS/HIV/STI, or other aspects of HGD, they retain the right to exempt their child from this instruction by filing a written request with the teacher or principal.

For an examples of passive permission forms with an opt-out option, see Resource 5.2 and Resource 5.3.

INVOLVING PARENTS IN THE HGD PROGRAM PLANNING

- Invite parents to serve on the HGD advisory committee or to be involved in related subcommittees or workgroups.

- Involve parents in planning a HGD information meeting for other parents.

- As discussed in Section 4, conduct a survey of current district parents to assess topics they think should be included in the HGD program and the appropriate grade levels for teaching these topics. See Resource 4.6 for an example of a parent survey to solicit parental perception of appropriate scope and sequence of HGD instructional topics.

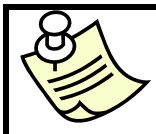
- Conduct a survey or informal focus groups to assess satisfaction with the HGD curriculum. What are they hearing from their children? What seems to be working well? Where could improvements be made?

SUPPORTING PARENTS AS THE PRIMARY SEXUALITY EDUCATORS OF THEIR CHILDREN

- Provide workshops to help families talk about family values and other aspects of human sexuality. The following resources may be of particular interest to parents.
    - **Resource 5.4 Are You an Askable Parent?**
    - **Resource 5.5 Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy**
    - **Resource 5.6 Talking Back: Ten Things Teens Want Parents to Know About Teen Pregnancy**
    - **Resource 5.7 Ten Tips for Parents of a Gay, Lesbian, Bisexual or Transgender Child**
    - **Resource 5.8 10 Tips for Parents on Talking about Sex with Your Child Who Has Developmental Disabilities**.
- Provide suggestions for educational activities to do at home with their children.
- Offer workshops, or information about workshops offered in the area, on child-rearing topics to increase parents' comfort and self-confidence in these areas.
- Provide reading lists of developmentally-appropriate books for parents and their children.
    - **Resource 5.9 Talking with Your Child About Sexuality: Annotated Resource List**

And finally, Resource 5.10 provides an example that summarizes a school district's partnership with parents and guardians. This statement addresses the role and involvement of parents in the HGD advisory committee, communication about the curriculum, and the opportunity that exists to exempt their children from HGD instruction.

- **Resource 5.10 Example of Statement of Partnership with Parents/Guardians: Stoughton Area School District**



Also see: DPI's Checklist for Making Family-School-Community Partnerships Work available at **www.dpi.wi.gov/fscp/bbchekpg.html**.

Resource 5.1

Sample Agenda:
HGD Parent Information Meeting

Welcome and Introductions (5 minutes)
Principal
HGD Advisory Committee member
Staff teaching HGD curriculum

Meeting Ground Rules

Rationale for teaching HGD at this grade level (5 minutes)

Questions parents/guardians have about the curriculum (5 minutes)
(post on newsprint)

Overview of the curriculum (30 minutes)
- Goals and objectives
- Description of selected activities
- Review of teaching materials
- District's approach to answering students' questions
- Approaches to communicate with parents about HGD instruction

Answer remaining questions (15 minutes)

Closure and adjourn to examine instructional materials

Resource 5.10

Example of Statement of Partnership with Parents/Guardians:
Stoughton Area School District (2005)

A Partnership with Parents/Guardians*

The instruction of students in Human Growth and Development is a partnership. The school's role is to teach human growth and development; the parent's role is to share factual information, explain and infuse family values. The goal of the partnership is to facilitate communication between parents, students and the school.

- Every three years the Stoughton School Board is required by state law to appoint an advisory committee composed of parents, teachers, school administrators, school board members, students, health care professionals, members of the clergy and other residents of the school district.

- Annually, parents will be mailed an outline of the human growth and development curriculum used in their child's grade level. Parents will be invited to preview all instructional materials well before information is presented in class. Materials shall be made available upon request. Videos will be made available at the school and/or public library.

- Parents may exempt their child from all or part of the human growth and development curriculum. If a student is exempted, he/she will be held accountable for an alternative study of health topics.

- Forms will be sent annually to parents 1) encouraging them to discuss the information with their child, 2) asking them to sign and return the form indicating that they have read the information, and 3) asking them to write or call if their child should not be included. Parents are urged to read the curriculum, talk to the teacher and view the materials before making the decision.

*For the sake of clarity and with no intent to offend, when the term parents is used it means parents and/or guardians.

Resource 5.2

Sample 1
MPS Opt-Out Request
(beginning of the *year*)

Dear Parent,

We are going to be learning about our bodies and how to keep them safe and healthy throughout the school year. Some of the instruction will include information about the reproductive system and human sexuality. The lessons we will be using have been reviewed by a community advisory board including parents, health experts and religious leaders. We welcome you to review the lessons by calling the school and setting up an appointment to come in to talk with your child's teacher or the principal. At times your son or daughter will be asked to talk with you to better understand your beliefs and values around these issues. We want to support your role as the main educator of your child about human sexuality.

Attached you will find an outline of the lessons to be taught this year. If you would like to have your child sit out during any of these lessons, please indicate which lessons on the form below and send it back to school with your child or mail it to the school office.

We look forward to working with you this year.

Sincerely,
(Names of teachers and Principal)

I would like my child _____ to be pulled out of the following class sessions of the human growth and development curriculum this year (use the attached outline):

_____

_____

Thank You,

Please print your name _____

Signature _____

Date _____

Resource 5.3

Sample 2
MPS Opt-Out Request
(beginning of *instructional unit*)

Dear Parent,

We are about to begin instruction about the reproductive system and human sexuality. The lessons we will be using have been reviewed by a community advisory board including parents, health experts and religious leaders. We welcome you to review the lessons by calling the school and setting up an appointment to come in to talk with your child's teacher or the principal. At times your son or daughter will be asked to talk with you to better understand your beliefs and values around these issues. We want to support your role as the main educator of your child about human sexuality.

Attached you will find an outline of the lessons to be taught. If you would like to have your child sit out during any of these lessons, please indicate which lessons on the form below. Hand this to the office staff, send it back to school with your child or mail it to the school office. We must receive it back by (date) __________________ or your child will be included in the learning opportunities.

We look forward to working with you this year.

Sincerely,
(Names of teachers and Principal)

- -

I would like my child __________________________________ to be pulled out of the following class sessions of the human growth and development curriculum (use the attached outline):

____

____

Thank You,

Please print your name _____________________________________

Signature ____

Date ____

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From Research to Practice

Are You an Askable Parent?

As a parents or caregiver, it is very important for you to be *askable*. What does that mean? How do adults become *askable*?

To be *askable* means that young people see you as approachable and open to questions. Being *askable* about sexuality is something that most parents and caregivers want but that many find very difficult. Adults may have received little or no information about sex when they were children. Sex may not have been discussed in their childhood home, whether from fear or out of embarrassment. Or, adults may worry about:

- Not knowing the *right* words or the *right* answers;
- Being *out of it* in the eyes of their young people;
- Giving too much or too little information; or
- Giving information at the wrong time.

Being *askable* is important. Research shows that youth with the least accurate information about sexuality and sexual risk behaviors may experiment more and at earlier ages compared to youth who have more information.[1,2,3,4,5] Research also shows that, when teens are able to talk with a parent or other significant adult about sex and about protection, they are less likely to engage in early and/or unprotected sexual intercourse than are teens who haven't talked with a trusted adult.[6,7,8,9] Finally, youth often say that they want to discuss sex, relationships, and sexual health with their parents—parents are their preferred source of information on these subjects.[10,11]

Because being *askable* is so important and because so many adults have difficulty initiating discussions about sex with their children, adults may need to learn new skills and become more confident about their ability to discuss sexuality. Here are some tips from experts in the field of sex education.

Talking with Young People about Sexuality

1. **Acquire a broad foundation of factual information from reliable sources.** Remember that sexuality is a much larger topic than sexual intercourse. It includes biology and gender, of course, but it also includes emotions, intimacy, caring, sharing, and loving, attitudes, flirtation, and sexual orientation as well as reproduction and sexual intercourse.
2. **Learn and use the correct terms for body parts and functions**. If you have difficulty saying some words without embarrassment, practice saying these words, in private and with a mirror, until you are as comfortable with them as with non-sexual words. For example, you want to be able to say "penis" as easily as you say "elbow."
3. **Think through your own feelings and values about love and sex**. Include your childhood memories, your first infatuation, your values, and how you feel about current sex-related issues, such as contraceptives, reproductive rights, and equality with regard to sex, gender, and sexual orientation. You must be aware of how you feel before you can effectively talk with youth.
4. **Talk *with* your child**. Listen more than you speak. Make sure you and your child have open, *two-way* communication—as it forms the basis for a positive relationship between you and your child. Only by listening to each other can you understand one another, especially regarding love and sexuality, for adults and youth often perceive these things differently.
5. **Don't worry about**—
   - Being "with it." Youth have that with their peers. From you, they want to know what you believe, who you are, and how you feel.
   - Being embarrassed. Your kids will feel embarrassed, too. That's okay, because love and many aspects of sexuality, including sexual intercourse, are highly personal. Young people understand this.

- Deciding which parent should have this talk. Any loving parent or caregiver can be an effective sex educator for his/her children.
- Missing some of the answers. It's fine to say that you don't know. Just follow up by offering to find the answer or to work with your child to find the answer. Then do so.

Talking with Young Children

1. **Remember that if someone is old enough to ask, she/he is old enough to hear the correct answer and to learn the correct word(s).**
2. **Be sure you understand what a young child is asking.** Check back. For example, you might say, "I'm not certain that I understand exactly what you are asking. Are you asking if it's okay to do this or why people do this?" What you don't want is to launch into a long explanation that doesn't answer the child's question.
3. **Answer the question when it is asked.** It is usually better to risk embarrassing a few adults (at the supermarket, for example) than to embarrass your child or to waste a teachable moment. Besides, your child would usually prefer it if you answer right then and softly. If you cannot answer at the time, assure the child that you are glad he/she asked and set a time when you will answer fully. "I'm glad you asked that. Let's talk about it on the way home."
4. **Answer *slightly* above the level you think your child will understand**, both because you may be underestimating him/her and because it will create an opening for future questions. But, don't forget that you are talking with a young child. For example, when asked about the differences between boys and girls, don't get out a textbook and show drawings of the reproductive organs. A young child wants to know what is on the *outside*. So, simply say, "A boy has a penis, and a girl has a vulva."
5. **Remember that, even with young children, you must set limits.** You can refuse to answer personal questions. "What happens between your father and me is personal, and I don't talk about it with anyone else." Also, make sure your child understands the difference between values and standards relating to his/her question. For example, if a child asks whether it is bad to masturbate, you could say, "Masturbation is not bad; however, we never masturbate in public. It is a *private* behavior." [values *versus* standards] You should also warn your child that other adults may have different *values* about this subject while they will hold to the same *standard*; that is, they may believe it is wrong and a private behavior.

Talking with Teens

1. **Recall how you felt when you were a teen.** Remember that adolescence is a difficult time. One moment, a teen is striving for separate identity and independence, and the next moment urgently needs an adult's support.
2. **Remember that teens want mutually respectful conversations.** Avoid dictating. Share your feelings, values, and attitudes *and* listen to and learn about theirs. Remember that you cannot dictate anyone else's feelings, attitudes, or values.
3. **Don't assume that a teen is sexually experienced or inexperienced, knowledgeable or naive.** Listen carefully to what your teen is saying and/or asking. Respond to the teen's actual or tacit question, not to your own fears or worries.
4. **Don't underestimate your teen's ability to weigh the advantages and disadvantages of various options.** Teens have values, and they are capable of making mature, responsible decisions, especially when they have all the needed facts and the opportunity to discuss options with a supportive adult. If you give your teen misinformation she/he may lose trust in you, just as he/she will trust you if you are a consistent source of clear and accurate information. Of course, a teen's decisions may be different from ones you would make; but that goes with the territory.

Being *askable* is a lifelong component of relationships. It opens doors to closer relationships and to family connections. It's never too late to begin!

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Written by Barbara Huberman, RN, MEd, and by Sue Alford, MLS

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2000 M Street NW, Suite 750 • Washington, DC 20036 USA • Phone: 202.419.3420 • Fax: 202.419.1448 • www.advocatesforyouth.org

Resource 5.5

Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy

The National Campaign to Prevent Teen Pregnancy has reviewed recent research about parental influences on children's sexual behavior and talked to many experts in the field, as well as to teens and parents themselves. From these sources, it is clear that there is much parents and adults can do to reduce the risk of kids becoming pregnant before they've grown up.

Presented here as "ten tips," many of these lessons will seem familiar because they articulate what parents already know from experience – like the importance of maintaining strong, close relationships with children and teens, setting clear expectations for them, and communicating honestly and often with them about important matters. Research supports these common sense lessons: not only are they good ideas generally, but they can also help teens delay becoming sexually active, as well as encourage those who are having sex to use contraception carefully.

Finally, although these tips are for parents, they can be used by adults more generally in their relationships with teenagers. Parents – especially those who are single or working long hours –often turn to other adults for help in raising their children and teens. If all these caring adults are on the same "wavelength" about the issues covered here, young people are given more consistent messages. So, What to Do?

1. Be clear about your own sexual values and attitudes.

Communicating with your children about sex, love, and relationships is often more successful when you are certain in your own mind about these issues. To help clarify your attitudes and values, think about the following kinds of questions:

- What do you really think about school-aged teenagers being sexually active, perhaps even becoming parents?
- Who is responsible for setting sexual limits in a relationship and how is that done, realistically?
- Were you sexually active as a teenager and how do you feel about that now? Were you sexually active before you were married? What do such reflections lead you to say to your own children about these issues?
- What do you think about encouraging teenagers to abstain from sex?
- What do you think about teenagers using contraception?

2. Talk with your children early and often about sex, and be specific.

Kids have lots of questions about sex, and they often say that the source they'd most like to go to for answers is their parents. Start the conversation, and make sure that it is honest, open, and respectful. If you can't think of how to start the discussion, consider using situations shown on television or in movies as conversation starters. Tell them candidly and confidently what you think and *why* you take these positions; if you're not

sure about some issues, tell them that, too. Be sure to have a two-way conversation, not a one-way lecture. Ask them what *they* think and what they know so you can correct misconceptions. Ask what, if anything, worries them.

Age-appropriate conversations about relationships and intimacy should begin early in a child's life and continue through adolescence. Resist the idea that there should be just one conversation about all this—you know, "the talk." The truth is that parents and kids should be talking about sex and love all along. This applies to *both* sons and daughters and to *both* mothers and fathers, incidentally. All kids need a lot of communication, guidance, and information about these issues, even if they sometimes don't appear to be interested in what you have to say. And if you have regular conversations, you won't worry so much about making a mistake or saying something not quite right, because you'll always be able to talk again.

Many inexpensive books and videos are available to help with any detailed information you might need, but don't let your lack of technical information make you shy. Kids need as much help in understanding the *meaning* of sex as they do in understanding how all the body parts work. Tell them about love and sex, and what the difference is. And remember to talk about the reasons that kids find sex interesting and enticing; discussing only the "downside" of unplanned pregnancy and disease misses many of the issues on teenagers' minds.

Here are the kinds of questions kids say they want to discuss:

- How do I know if I'm in love? Will sex bring me closer to my girlfriend/boyfriend?
- How will I know when I'm ready to have sex? Should I wait until marriage?
- Will having sex make me popular? Will it make me more grown-up and open up more adult activities to me?
- How do I tell my boyfriend that I don't want to have sex without losing him or hurting his feelings?
- How do I manage pressure from my girlfriend to have sex?
- How does contraception work? Are some methods better than others? Are they safe?
- Can you get pregnant the first time?

In addition to being an "askable parent," be a parent with a point of view. Tell your children what you think. Don't be reluctant to say, for example:

- I think kids in high school are too young to have sex, especially given today's risks.
- Whenever you do have sex, always use protection against pregnancy and sexually transmitted diseases until you are ready to have a child.
- Our family's religion says that sex should be an expression of love within marriage.

- Finding yourself in a sexually charged situation is not unusual; you need to think about how you'll handle it *in advance*. Have a plan. Will you say "no"? Will you use contraception? How will you negotiate all this?
- It's okay to think about sex and to feel sexual desire. Everybody does! But it's not okay to get pregnant/get somebody pregnant as a teenager.
- One of the many reasons I'm concerned about teens drinking is that it often leads to unprotected sex.
- (For boys) Having a baby doesn't make you a man. Being able to wait and acting responsibly does.
- (For girls) You don't have to have sex to keep a boyfriend. If sex is the price of a close relationship, find someone else.

By the way, research clearly shows that talking with your children about sex does *not* encourage them to become sexually active. And remember, too, that your own behavior should match your words. The "do as I say, not as I do" approach is bound to lose with children and teenagers, who are careful and constant observers of the adults in their lives.

3. Supervise and monitor your children and adolescents.

Establish rules, curfews, and standards of expected behavior, preferably through an open process of family discussion and respectful communication. If your children get out of school at 3 pm and you don't get home from work until 6 pm, who is responsible for making certain that your children are not only safe during those hours, but also are engaged in useful activities? Where are they when they go out with friends? Are there adults around who are in charge? Supervising and monitoring your kids' whereabouts doesn't make you a nag; it makes you a parent.

4. Know your children's friends and their families.

Friends have a strong influence on each other, so help your children and teenagers become friends with kids whose families share your values. Some parents of teens even arrange to meet with the parents of their children's friends to establish common rules and expectations. It is easier to enforce a curfew that all your child's friends share rather than one that makes him or her different-but even if your views don't match those of other parents, hold fast to your convictions. Welcome your children's friends into your home and talk to them openly.

5. Discourage early, frequent, and steady dating.

Group activities among young people are fine and often fun, but allowing teens to begin steady, one-on-one dating much before age 16 can lead to trouble. Let your child know about your strong feelings about this throughout childhood – don't wait until your young teen proposes a plan that differs from your preferences in this area; otherwise, he or she will think you just don't like the particular person or invitation.

6. Take a strong stand against your daughter dating a boy significantly older than she is. And don't allow your son to develop an intense relationship with a girl much younger than he is.

Older guys can seem glamorous to a young girl – sometimes they even have money and a car to boot! But the risk of matters getting out of hand increases when the guy is much older than the girl. Try setting a limit of no more than a two (or at most three) year age difference. The power differences between younger girls and older boys or men can lead girls into risky situations, including unwanted sex and sex with no protection.

7. Help your teenagers to have options for the future that are more attractive than early pregnancy and parenthood.

The chances that your children will delay sex, pregnancy, and parenthood are significantly increased if their futures appear bright. This means helping them set meaningful goals for the future, talking to them about what it takes to make future plans come true, and helping them reach their goals. Tell them, for example, that if they want to be a teacher, they will need to stay in school in order to earn various degrees and pass certain exams. It also means teaching them to use free time in a constructive way, such as setting aside certain times to complete homework assignments. Explain how becoming pregnant – or causing pregnancy – can derail the best of plans; for example, child care expenses can make it almost impossible to afford college. Community service, in particular, not only teaches job skills, but can also put teens in touch with a wide variety of committed and caring adults.

8. Let your kids know that you value education highly.

Encourage your children to take school seriously and set high expectations about their school performance. School failure is often the first sign of trouble that can end in teenage parenthood. Be very attentive to your children's progress in school and intervene early if things aren't going well. Keep track of your children's grades and discuss them together. Meet with teachers and principals, guidance counselors, and coaches. Limit the number of hours your teenager gives to part-time jobs (20 hours per week should be the maximum) so that there is enough time and energy left to focus on school. Know about homework assignments and support your child in getting them done. Volunteer at the school, if possible. Schools want more parental involvement and will often try to accommodate your work schedule, if asked.

9. Know what your kids are watching, reading, and listening to.

The media (television, radio, movies, music videos, magazines, the Internet) are chock full of material sending the wrong messages. Sex rarely has meaning, unplanned pregnancy seldom happens, and few people having sex ever seem to be married or even especially committed to anyone. Is this consistent with your expectations and values? If not, it is important to talk with your children about what the media portray and what you think about it. If certain programs or movies offend you, say so, and explain why. Be "media literate" – think about what you and your family are watching and reading.

Encourage your kids to think critically: ask them what they think about the programs they watch and the music they listen to.You can always turn the TV off, cancel subscriptions, and place certain movies off limits. You will probably not be able to fully control what your children see and hear, but you can certainly make your views known and control your own home environment.

10. These first nine tips for helping your children avoid teen pregnancy work best when they occur as part of strong, close relationships with your children that are built from an early age.

Strive for a relationship that is warm in tone, firm in discipline, and rich in communication, and one that emphasizes mutual trust and respect. There is no single way to create such relationships, but the following habits of the heart can help:

- Express love and affection clearly and often. Hug your children, and tell them how much they mean to you. Praise specific accomplishments, but remember that expressions of affection should be offered freely, not just for a particular achievement.
- Listen carefully to what your children say and pay thoughtful attention to what they do.
- Spend time with your children engaged in activities that suit their ages and interests, not just yours. Shared experiences build a "bank account" of affection and trust that forms the basis for future communication with them about specific topics, including sexual behavior.
- Be supportive and be interested in what interests them. Attend their sports events; learn about their hobbies; be enthusiastic about their achievements, even the little ones; ask them questions that show you care and want to know what is going on in their lives.
- Be courteous and respectful to your children and avoid hurtful teasing or ridicule. Don't compare your teenager with other family members (i.e., why can't you be like your older sister?). Show that you expect courtesy and respect from them in return.
- Help them to build self-esteem by mastering skills; remember, self-esteem is earned, not given, and one of the best ways to earn it is by *doing* something well.
- Try to have meals together as a family as often as possible, and use the time for conversation, not confrontation.

A final note: it's never too late to improve a relationship with a child or teenager. Don't underestimate the great need that children feel—at all ages—for a close relationship with their parents and for their parents' guidance, approval, and support.

Source: Milwaukee Public Schools Human Growth and Development Curriculum (2004)

Resource 5.6

Talking Back: Ten Things Teens Want Parents to Know About Teen Pregnancy

Introduction

Teens hear advice on all kinds of issues from their parents, teachers, and other adults in their lives. But they don't often get asked to offer it. Over the past year, the National Campaign to Prevent Teen Pregnancy has been asking teens from all over the country a fairly simple question: If you could give your parents and other important adults' advice about how to help you and your friends avoid pregnancy, what would it be? The following ten tips represent the major themes we heard from teens.

You may be surprised to learn that young people do want to hear from parents and other adults about sex, love, and relationships. They say they appreciate—even crave—advice, direction, and support from adults who care about them. But sometimes, they suggest, adults need to change *how* they offer their guidance. Simply put, they want real communication, not lectures and not threats.

The National Campaign would like to acknowledge the contributions of the many young people who have offered their suggestions for this publication, including the National Campaign's *Youth Leadership Team*, the readers of *Teen People*, and the teens who participated in our focus groups, answered our polling questions, visited our website, or told us their stories in communities we've visited around the country. We would also like to thank our informal group of adult advisors who reviewed drafts of the brochure.

We hope that *Talking Back: Ten Things Teens Want Parents to Know About Teen Pregnancy* offers parents and other adults comfort that their efforts to help teens do make a difference—as well as gives the kind of practical advice that will make the job a little easier.

Sarah Brown
Director
National Campaign to Prevent Teen Pregnancy
April 1999

Source: National Campaign to Prevent Teen Pregnancy

Ten Things Teens Want Parents to Know About Teen Pregnancy

1. **Show us why teen pregnancy is such a bad idea.** For instance, let us hear directly from teen mothers and fathers about how hard it has been for them. Even though most of us don't want to get pregnant, sometimes we need real-life examples to help motivate us.
2. **Talk to us honestly about love, sex, and relationships.** Just because we're young doesn't mean that we can't fall in love or be deeply interested in sex. These feelings are very real and powerful to us. Help us to handle the feelings in a safe way—without getting hurt or hurting others.
3. **Telling us not to have sex is not enough.** Explain why you feel that way, and ask us what we think. Tell us how you felt as a teen. Listen to us and take our opinions seriously. And no lectures, please.
4. **Whether we're having sex or not, we need to be prepared.** We need to know how to avoid pregnancy and sexually transmitted diseases.
5. **If we ask you about sex or birth control, don't assume we are already having sex.** We may just be curious, or we may just want to talk with someone we trust. And don't think giving us information about sex and birth control will encourage us to have sex.
6. **Pay attention to us before we get into trouble.** Programs for teen moms and teen fathers are great, but we all need encouragement, attention, and support. Reward us for doing the right thing - even when it seems like no big thing. Don't shower us with attention only when there is a baby involved.
7. **Sometimes, all it takes not to have sex is not to have the opportunity.** If you can't be home with us after school, make sure we have something to do that we really like, where there are other kids and some adults who are comfortable with kids our age. Often we have sex because there's not much else to do. Don't leave us alone so much.
8. **We really care what you think, even if we don't always act like it.** When we don't end up doing exactly what you tell us to, don't think that you've failed to reach us.
9. **Show us what good, responsible relationships look like.** We're as influenced by what you do as by what you say. If you demonstrate sharing, communication, and responsibility in your own relationships, we will be more likely to follow your example.
10. **We hate "The Talk" as much as you do.** Instead, start talking with us about sex and responsibility when we're young, and keep the conversation going as we grow older.

Source: National Campaign to Prevent Teen Pregnancy

Resource 5.7

Ten Tips for Parents* of a Gay, Lesbian, Bisexual, or Transgender Child

1. **Engage with your child.** Your gay, lesbian, bisexual, or transgender (GLBT) child requires and deserves the same level of care, respect, information, and support as non-GLBT children. Ask questions, listen, empathize, share, and just be there for your child.

2. **Go back to school.** Get the facts about sexual orientation and gender identity. Learn new language and the correct terminology to communicate effectively about sexual orientation and gender identity. Challenge yourself to learn and go beyond stereotyped images of GLBT people.

   Here's a quick lesson on two frequently misunderstood terms:

   Sexual orientation—Describe to whom a person feels attraction: people of the opposite gender, the same gender, or both genders.

   Gender identity—A person's inner sense of gender—male, female, some of each, neither. Transgender people have a gender identity that is different from the gender to which they were born or assigned at birth.

   Some people ask, "Isn't transgender just like being gay?" No. Transgender describes a person's internal sense of gender identity. Sexual orientation describes a person's feeling of attraction toward other people. Transgender people have some issues in common with gay, lesbian, and bisexual communities, but gender identity is ***not*** the same as sexual orientation.

3. **Get to know the community.** What resources are available? Find out if there is a Gay/Straight Alliance at school, a community group for GLBT and questioning teens, a bookstore with a selection of books on GLBT issues, or a GLBT community center nearby.

4. **Explore the Internet.** There is a growing amount of excellent information on the World Wide Web that connects people with support and materials on these important topics. Two excellent web sites are Parents, Families & Friends of Lesbians and Gays (**www.pflg.org**), and Gay, Lesbian and Straight Education Network (**www.glsen.org/cgi-bin/iowa/all/about/index.html**).

5. **Find out where your local Parents, Families & Friends of Lesbians and Gay (PFLAG) meets.** Many parents say that their connections with other parents of GLBT kids made a world of difference in their progress toward understanding their young people. Finding another person you can trust to share your experience with is invaluable. Many people have gone through similar things and their support, lessons learned, and empathy can be very valuable.

6. **Don't make it ALL there is…**just because your child has come out as GLBT does not mean that young person's whole world revolves around sexual orientation or gender identity. It will be a big part of who the youth is, especially during the process of figuring it all out, including what it means to be GLBT. Still, being GLBT isn't the sum of life for your child, and it is vital to encourage your child in other aspects of life, such as school, sports, hobbies, friends, and part-time jobs.

7. **ASK your child *before* you "come out" to others on the child's behalf.** Friends and family members might have questions or want to know what's up; but it is most important to be respectful of what your child wants. Don't betray your child's trust!

8. **Praise your GLBT child for coming to you to discuss this issue.** Encourage the youth to continue to keep you "in the know." If your child turns to you to share personal information, you must be doing something right! You are askable. You're sending out consistent verbal and non-verbal cues that say, "Yes, I'll listen. Please talk to me!" Give yourself some credit—your GLBT child chose to come to you. Congratulations!

9. **Find out what kind of support, services, and education are in place at your child's school.** Does the school and/or school district have a non-discrimination policy? Is there a GLBT/straight support group? Do you know any "out" people, or their friends and loved ones, to whom you can turn for information? (Before doing so, again refer to tip number 7, above. *Ask* your child if it's okay for you to "come out" about the child.)

10. **Educate yourself on local, state, and national laws and policies regarding GLBT people.** On the national level, GLBT people are still second-class citizens in regard to some national policies and their rights are not guaranteed by law. Consider educating yourself about this and finding out what you can do to work toward extending equal rights to GLBT people in the United States.

    ***Please note:** These tips can also be useful for other trusted adults in the GLBT young person's life, explaining how a caring adult can be there for GLBT youth.

Source: Lisa Mauer, MS, CFLE, ACSE, Coordinator, The Center for LGBT Education, Outreach and Services, Ithaca College

Ten Things Teens Want Parents to Know About Teen Pregnancy

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2. **Talk to us honestly about love, sex, and relationships.** Just because we're young doesn't mean that we can't fall in love or be deeply interested in sex. These feelings are very real and powerful to us. Help us to handle the feelings in a safe way—without getting hurt or hurting others.
3. **Telling us not to have sex is not enough.** Explain why you feel that way, and ask us what we think. Tell us how you felt as a teen. Listen to us and take our opinions seriously. And no lectures, please.
4. **Whether we're having sex or not, we need to be prepared.** We need to know how to avoid pregnancy and sexually transmitted diseases.
5. **If we ask you about sex or birth control, don't assume we are already having sex.** We may just be curious, or we may just want to talk with someone we trust. And don't think giving us information about sex and birth control will encourage us to have sex.
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8. **We really care what you think, even if we don't always act like it.** When we don't end up doing exactly what you tell us to, don't think that you've failed to reach us.
9. **Show us what good, responsible relationships look like.** We're as influenced by what you do as by what you say. If you demonstrate sharing, communication, and responsibility in your own relationships, we will be more likely to follow your example.
10. **We hate "The Talk" as much as you do.** Instead, start talking with us about sex and responsibility when we're young, and keep the conversation going as we grow older.

Source: National Campaign to Prevent Teen Pregnancy

Resource 5.8

Ten Tips for Talking About Sexuality with Your Child Who Has Developmental Disabilities

Conversations about sexuality can yield many benefits when you talk with your child who has developmental disabilities. The positive effects for your child include, not only an understanding of sexuality, but also opportunities to learn, grow, and build skills for life. Talking about sexuality sets the stage for talking, without guilt or embarrassment, about body parts and their functions. It sets the stage for your child to articulate life goals. It equips young people to understand behaviors that are inappropriate in public or that are destructive to relationships, trust, and self-esteem. It enables young people to recognize and prevent abuse and exploitation. Many parents also observe their children increasing in self-esteem and self-empowerment as they master key concepts related to sexuality.

Young people who have developmental disabilities deserve accurate, age and developmentally appropriate sexual health information. This can sometimes be challenging for parents and young people if some learning channels are blocked or if commonly used teaching tools (such as diagrams and charts) are less than useful for children who learn in non-traditional ways. Nevertheless, the numerous benefits are worth the effort. Here are some tips and ideas for beginning your conversation:

1. **Use pictures as often as you can**. Photos of family or friends can be a springboard for talking about relationships and social interactions. These give important and immediate context to your discussions, which is key for these children who have success with concrete ideas.

2. **Use repetition in providing small amounts of information over time**. Check that your child understands by asking questions that put the information in a practical context. (What could Cousin Laverna have said?) Use opportunities to repeat key ideas in other settings – for instance, while watching television programs that deal with relationships or sexuality issues.

3. **Draw, copy, or buy a full body drawing or chart**. This is a concrete way to show where body parts are and what they do.

4. **For more involved tasks (such as personal hygiene related to menstruation), try to break down the activity into several steps**. Frequently review the steps with your child and always provide feedback and praise. If you are unsure if your steps are concrete and understandable, write them down and try following them yourself. Did you leave *anything* out? Using a pad or tampon during menstruation or cleaning beneath the foreskin of the penis may seem straightforward, but these activities require several separate steps in a particular order.

5. **Repeat information often, and offer feedback and praise**. Reinforce important concepts frequently.

6. **Practice!** Make sure your child has plenty of opportunities to try out his/her skills.

7. **Use existing resources**. Visit the library and check out books and videos about talking with your kids about sexuality. Also use the World Wide Web.

8. **Network with other parents**. Share your insights and listen to theirs. Involve others by communicating with teachers, coaches, and caseworkers about the topics you are discussing. Share ways they can reinforce these lessons at school, work, or on the playing field.

9. **Recognize and validate your child's feelings**. This is a unique opportunity to get to know your child better.

10. **Don't be afraid to say, "I don't know the answer to that question."** But, be sure to follow up with, "Let's find out together!" Then do so.

There is no single approach that is always best. As a parent, you have the opportunity to investigate and experiment, to be creative and to learn from your successes as well as your missteps!

RECOMMENDED RESOURCES

- *Positive Approaches: A Sexuality Guide for Teaching Developmentally Disabled Persons* (1991)

- *Talking Sex! Practical Approaches and Strategies for Working with People Who Have Developmental Disabilities When the Topic Is Sex* (1999)

To purchase these publications, contact Planned Parenthood of Tompkins County's Education Department at 607-273-1526.

Source:
Lisa Maurer, MS, CFLE, ACSE, Consultant and Trainer, Planned Parenthood of Tomkins County's Education Department

Resource 5.9

Talking with Your Child About Sexuality: Annotated Resource List

The National Campaign to Prevent Teen Pregnancy and SIECUS have each developed lists of easily available resources for parents, most of which are free or inexpensive. Although these materials are created for parents, other adults who interact with children and teenagers, including relatives, trusted friends and neighbors, teachers, coaches, and counselors, will likely find them useful. Publications from other sources are also included in the list below. We encourage you to investigate your local bookstores, schools, faith communities, neighborhood and community centers, libraries, and youth-serving organizations for additional resources.

Resources from the National Campaign to Prevent Teen Pregnancy, www.teenpregnancy.org

- ***Parent Power: What Parents Need to Know and Do to Help Prevent Teen Pregnancy***
- ***El poder de los padres: Lo que los padres deben saber y hacer para ayudar a prevenir el embarazo en los adolescents***
- ***Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy***
- ***Talking Back: Ten Things Teens Want Adults to Know About Teen Pregnancy***
- ***Parents Matter: Tips for Raising Teenagers***
- ***Consejos para evitar el embarazo en los adolescents***

Resources from SIECUS, www.siecus.org:

- ***Como Hablar con Sus Hijos Sobre el Sida.***
  Para ayudar a padres hablar con sus hijos acerca del VIh/SIDA. Este folleto ofrece informacion basica acerca de VHI/SIDA y guias apropiadas para edades especificas. This is an adaptation of How to Talk to Your Children About AIDS for Spanish-speaking families (1998).
- ***Families Are Talking.***
  Newsletters with information to help parents and caregivers talk to their children about sexuality and related issues. Separate volumes address the media, family diversity, puberty, sexuality education, HIV/AIDS, abstinence, body image and self-esteem.

- ***How to Talk to Your Children About AIDS.***
  Help for parents who want to talk to their children in preschool through high school about sexuality issues (1994).

- ***Innovative Approaches to Increase Parent-Child Communication about Sexuality: Their Impact and Examples from the Field.***
  Is intended to guide parents and caregivers, policymakers, public agencies, and educators in their quest for high-quality parent-child communication programs (2002).

- ***La familia habla***
  Un boletin informativo trimestral patrocinado. Contiene informacion para ayudar a las familias a establecer una communication mas abierta sobre temas relacionados con la sexualidad. Incluyen sobre los medios de comunicacion, la diversidad familiar, la pubertad, la educacion sexual, el VHI/SIDA.

- ***Now What Do I Do?***
  Help for parents of pre-teens who want to advise their children on subjects such as puberty, love, dating, contraception, masturbation, and sexually transmitted diseases (1996).

Additional publications of interest to parents:

Campaign for Our Children (CFOC). CFOC produces ad campaigns encouraging parent-child communication and sexual abstinence among teens. CFOC also hosts two web sites: one for parents with a chat room, and one geared toward adolescents. Contact: Campaign for Our Children, 120 West Fayette Street, Suite 1100, Baltimore, MD 21201. Tel: 410-576-9015 and **www.cfoc.org.**

Family Connections. A series of three booklets (for age groups birth to 7, 8 to 13, and 14 to 18) that covers parent/child communication skills, self-esteem for children, teen pregnancy, contraception, sexually transmitted diseases (STDs), and the media's influence on children. Contact: Center for Adolescent Pregnancy Prevention, Family Health Council, Inc., 460 Penn Avenue, Suite 600, Pittsburgh, PA 15222. Tel: 412-288-2130.

The Gentle Art of Communicating With Kids: Toddlers to Teens by Suzette Haden Elgin, Ph.D. This book outlines techniques to help parents discuss with their children more than thirty tough topics, including handling children reluctant to go to bed, bolstering self-esteem, and preventing teen pregnancy and drug abuse. Contact: John Wiley & Sons, Inc. website at **http://www.wiley.com/WileyCDA/Section/index.html.**

How to Talk to Children About Sex. Part of the Family Forum Library, this booklet provides parents with answers to children's most common questions about sex. Another title in the same series, *Positive Parent/Child Communications,* instructs parents on ways to communicate more effectively with their children and to build their self-esteem. Contact: The Bureau for At-Risk Youth, 45 Executive Drive, P.O. Box9121, Plainview, NY 11803-9020. Tel: 800-999-6884. Web: **www.at-risk.com.**

How to Talk So Kids Will Listen & Listen So Kids Will Talk by Adele Faber and Elaine Mazlish. Available in most bookstores, this book walks parents through a wide range of typical talks with kids, while at the same time encouraging them to listen fully to what their children are saying. Contact: HarperCollins Publishers at **www.harpercollins.com.**

The National Parenting Center. This web site offers several pamphlets in their On-line Adolescence Reading Room on communicating with pre-teens and teens. It also hosts more than 100 chat rooms for parents on the challenges of parenting and offers links to other web sites. Contact: The National Parenting Center. Tel: 800-753-6667. Web: **www.tnpc.com.**

Now What Do I Do? How To Give Your Pre-Teens Your Messages. This booklet helps parents of 10- to 12-year-old children communicate about teen pregnancy, contraception, self-esteem, media influences, unwanted sexual attention, and homosexuality. A sister publication, *On No! What Do I Do Now?* (also available in Spanish), helps parents communicate their values about sexuality to their children. Contact: Sexuality Information and Education Council of the United States, 130 West 42nd Street, Suite 350, New York, NY 10036-7802. Tel: 212-819-9770. Web: **www.siecus.org.**

Parent's Guide to Talking With Kids About Sex. Published in conjunction with NBC television's "The More You Know" public service announcements, this booklet from the Henry J. Kaiser Family Foundation and Children Now offers tips and techniques on talking about sex and sexuality for parents of children ages 8 to 12. Answers to children's most common questions are included. Tel: 888-730-2777.

Raising Healthy Kids: Families Talk About Sexual Health. This 20-minute DVD/video for parents of young children (birth to 7) stresses the importance of talking with kids, as well as the messages sent to young children by their parent's behaviors. Topics covered include self-touching, appropriate and inappropriate touching, proper labeling of body parts, and taking advantage of moments when children are seeking information. Part 1—parents of youth children; Part 2—parents of preadolescents and adolescents. Also available in Spanish. Contact: Family Health Productions, P.O. Box 1639, Gloucester, MA 01930. Tel: 978-282-9970. Web: **www.abouthealth.com.**

Supporting Your Adolescent: Tips for Parents. This on-line resource (pdf and html) focuses on helping young people make successful transitions to adulthood. In addition to including advice on parenting and positive family interaction, the resource suggests supportive resources that may be found within one's community. Contact: National Clearinghouse on Families and Youth, P.O. Box 13505, Silver Spring, MD 20911-3505; tel: 301-608-8098 or web: **www.ncfy.com**.

Talking About Sex—A Guide for Families. This video and companion kit for families with children ages 10 to 14 contains factual information and discussion guides about such topics as anatomy, HIV/AIDS. Contact: Planned Parenthood Federation of America, Inc., 434 West 33d Street, New York, NY 10001. Web**: www.ppfa.org**.

Talking to Adolescents About Sex. This pamphlet describes how to talk with teens about STDs, values, and the physical and emotional changes they are experiencing, as well as how to provide your teen with decision-making skills. Contact: Channing Bete Company, Inc., One Community Place, South Deerfield, MA 01373-0200. Tel: 800-477-4776. Web: **www.channing-bete.org**.

Talking With Kids About Tough Issues. A joint project of the Henry J. Kaiser Family Foundation and Children Now, this booklet encourages parents to explore their own values and beliefs in order to better communicate them to their children. Topics covered include HIV/AIDS, sex and sexuality, violence, and drugs and alcohol. Contact: Children Now, 355 Lexington Avenue, 11th Floor, New York, NY 10017. Tel: 800-244-5344. Web: **www.childrennow.org**. Web versions available at **www.talkwithkids.org**.

"Talking With" Pamphlet Series. The pamphlet series includes discussion guides to help parents talk with children and teens about birth control, abstinence, sexual responsibility, pelvic exams, menstruation, HIV/AIDS, drugs, and violence. Single copy samples are free, and bulk orders are available for purchase. A catalog listing pamphlets on many other issues is also available. Contact: ETR Associates, P.O. Box 1830, Santa Cruz, CA 95601-1830. Tel: 800-321-4407. Web: **www.etr.org.**

Talking With your Child About Sex by Mary S. Calderone and James W. Ramey. Available in most bookstores, ***Talking With Your Child About Sex*** offers answers to questions children of different ages ask about sex. Contact: Ballatine Books, 201 East 50th Street, New York, NY 10022. Web: **www.campusi.com**.

Talking With Your Teen About Sex and ***Talking With Your Child About Sex***. These pamphlets can be accessed (and printed) at the National PTA's web site. The version for parents of teens addresses HIV/AIDS, peer pressure avoidance skills, and date rape. ***Talking With Your Child*** offers information about reproduction, the importance of strengthening self-esteem in the early years, and the necessity of communicating values. Tel.: 800-307-4782. Web: **www.pta.org/**.

Ten Tips for Parents: To Help Their Children Avoid Teen Pregnancy. This guide presents "ten tips," many of these lessons will seem familiar because they articulate what parents already know from experience–like the importance of maintaining strong, close relationships with children and teens, setting clear expectations for them, and communicating honestly and often with them about important matters. Contact: the National Campaign to Prevent Teen Pregnancy. Tel: 202-478-8500. Web: **www.teenpregnancy.org/resources/reading/tips/tips.asp**

Unlocking the Secret: A Parent's Guide to Communicating With Your Kids. This guide, a part of the media program called "Not Me, Not Now" in New York, offers concrete ways to begin to talk about sexuality. Web: **www.notmenotnow.org**.

You and Your Adolescent: A Parent's Guide for Ages 10-20, by Laurence Steinberg, Ph.D., and Ann Levine. The newly revised edition, currently available in bookstores, includes tips on parenting and describes the warning signs for pre-teen and teen risky sexual behavior and tobacco, alcohol, and marijuana use. Contact: Harper Collins Publishers, Inc., 10 East 53rd Street, New York, NY 10022. Web: **www.amazon.com**.

6.0 Effective HGD Curriculum & Instruction

OVERVIEW

This section provides information and resources to help districts select a human growth and development (HGD) curriculum that is likely to result in their students acquiring the knowledge, attitudes, skills, and intentions that will contribute to their health and well-being. It begins with a reminder to consider the specific needs of youth in the community, and then reviews research findings on effective HGD instruction. It discusses what is currently known about the effectiveness of comprehensive and abstinence-only-until-marriage programs. This section then provides information and resources related to additional factors that must be considered in developing or selecting a HGD curriculum for a particular school community including acceptability and implementation issues.

The selection of a HGD curriculum requires weighing many factors to determine the "best fit" for a particular school or school district. Some of these factors include the:

- Needs of children and youth
- Parental support
- State academic standards
- Scope and sequence for K-12 instruction
- Effectiveness of the curriculum
    - Health outcomes
    - Best practices
- Acceptability in terms of community standards
    - Cultural factors
    - Perspectives on abstinence-only messages
- Implementation issues
    - Ease of replication and adaptability

This section discusses each of these factors and includes resources for districts and advisory committees to use as they review, develop, and implement HGD programs in Wisconsin schools. It also includes references to additional sources for more information on each of the factors.

NEEDS OF CHILDREN AND YOUTH

As discussed in Section 3, the particular educational needs of children and youth in the school district should be the primary consideration in development and selection of a HGD curriculum. Seldom is a complete profile of these young people available and so county, state, and even national data can be used to understand behavioral trends and educational needs. For young children little quantifiable data exists, even at the state and national levels, about knowledge and attitudes related to sexuality to guide HGD curricular development. State academic standards and national guidelines provide a useful framework for program development at the local level.

PARENTAL SUPPORT

The vast majority of Americans agree that sexuality education should be taught in schools. This was the conclusion of the recently published report, *Sex Education in America*, based on nationwide telephone survey of the general public and public middle and high schools' principals conducted by National Public Radio, the Kaiser Family Foundation, and Harvard's Kennedy School of Government (NPR et al, 2004). The report is available at **www.kff.org**.

However, and not surprisingly, there continue to be significant differences about what kind of sexuality education should be taught. According to *Sex Education in America*, 15% of Americans believe schools should teach only about abstinence from sexual intercourse and should not provide information on how to obtain and use condoms and contraception. Almost half (46%) of Americans believe an "abstinence-plus" approach that teaches that abstinence is the best approach but also teaches about condoms and contraceptives. The survey also found that parents want sexuality education classes to cover topics that are perceived as controversial by many administrators and teachers. At least 75% of parents say sexuality education classes should cover how to use condoms and other forms of birth control, as well as provide information on abortion and sexual orientation.

STATE ACADEMIC STANDARDS

Traditionally, HGD has been taught as part of Health Education and/or Family and Consumer Education. These will continue to be the primary subjects in which HGD instruction is provided, but there are other opportunities to teach and reinforce sexuality education content and skills. Because the topic of sexuality is so broad, sexuality education can be integrated into Science, Language Arts, Social Studies, as well as other subject areas. It may be useful for teachers in Health Education, Family and Consumer Education, Developmental Guidance, Teenage Parent programs, Science, Language Arts, Social Studies and other subjects to discuss ways sexuality is addressed in their various curricula so students receive coordinated instruction. School districts are encouraged to plan the HGD curriculum with attention to K-12 sequencing and opportunities to coordinate and integrate HGD with other subjects.

Human Growth and Development Connections with the State Standards in Health Education

Wisconsin has developed academic standards in 12 subjects to specify what students should know and be able to do, what they might be asked to do to give evidence of standards, and how well they must perform. The *content standards* are broad statements that tell what students should know and be able to do. The *performance standards* explain how students will demonstrate by the end of grades 4, 8, and 12 that they are meeting the content standards. *Proficiency standards* indicate how well students must perform and such standards have not been developed for health education.

Wisconsin's Model Academic Standards for Health Education (**www.dpi.wi.gov/standards/pdf/health.pdf**) are based on characteristics of an individual who is health-literate. A health-literate individual is a:

- critical thinker and problem solver,
- self-directed learner,
- effective communicator, and
- responsible and productive citizen.

Each of the 7 content standards, and related performance standards, contribute to the knowledge and skills of a health-literate person. The Model Academic Standards for Health Education are voluntary and schools are not required to use a specific curriculum to address the standards. They do, however, provide guidance for content priorities. The health education standards do not specifically mention HGD, HIV, STI, or pregnancy prevention.

See Resource 6.1 Wisconsin's Academic Standards for Health Education and HGD

Human Growth and Development Connections with the State Standards in Family and Consumer Education

Wisconsin's Model Academic Standards have also been established for Family and Consumer Education (FCE). The academic standards identify expectations of what students know, and can do, and can show how they have met content standards at introductory (by the end of 6th grade), intermediate (by the end of 8th grade), and advanced levels of study (by the end of 12th grade).

Like the Health Education standards, the FCE academic standards serve as guidelines for schools, but decisions about what, how much, and when the core concepts are taught to students reside with local districts. And like the academic standards for Health Education, the academic standards for FCE are designed to support and complement the role of the family. Resource 6.2 describes ways in which HGD instruction might contribute to meeting the FCE standards (**www.dpi.wi.gov/standards/pdf/face.pdf**).

See Resource 6.2 Family and Consumer Education Standards Related to HGD

SCOPE AND SEQUENCE

A Scope and Sequence provides a description of the topics taught (scope) and the progression (sequence) for which the topics are introduced or reinforced at various grade levels. Local HGD advisory committee and program planners will determine the level of detail that will be most useful to them.

SIECUS publishes *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade* to help school districts and educators plan developmentally-appropriate HGD instruction. The original 1991 *Guidelines* were created by a national task force of representatives from the U.S. Centers for Disease Control and Prevention, the American Medical Association, the National School Boards Association, the National Education Association, Planned Parenthood Federation of America, as well as representatives of other organizations and school-based sexuality education teachers to create an ideal model of comprehensive sexuality education. These guidelines identify six key concepts in a comprehensive sexuality education program and developmental messages for each of four levels, including early elementary school, upper elementary school, middle school, and high school. SIECUS recommends that school-based HGD education programs be thoughtfully and carefully developed to respect the diversity of values and beliefs in a community. *The Guidelines for Comprehensive Sexuality Education. Third Edition* (2004) is available at **www.siecus.org/pubs/guidelines/guidelines.pdf**.

Resource 6.3 provides the Milwaukee Public Schools' K-12 Scope and Sequence of HGD Curriculum Concepts. Resource 6.4 is a portion of Oconomowoc's HGD Scope and Sequence that illustrates how selected topics are introduced and developed in subsequent years. The Stoughton Area School District publishes grade-specific booklets describing the mission, objectives, tips for parents, and other key elements of the HGD instructional program for each grade level.

See Resource 6.3 **Milwaukee Public School HGD Scope and Sequence of HGD Concepts**

See Resource 6.4 **Oconomowoc HGD Scope and Sequence (selection)**

EFFECTIVENESS OF THE CURRICULUM

One important factor to consider in developing or selecting a HGD curriculum is whether it is effective. Effectiveness can be defined, and measured, in different ways. The research literature defines "effective" adolescent sexual risk behavior prevention programs as those for which "rigorous outcome evaluation has yielded evidence of a significant positive effect on adolescents' key sexual risk behaviors, pregnancy, birth, STI, or HIV infection rates – among at least one subgroup of youth in at least one evaluation study" (J. Solomon, 2004). Rigorous outcome evaluations refer to research studies that use experimental or quasi-experimental designs to analyze whether a program

made a difference in terms of selected behaviors or health outcomes. Not all evaluation studies of curricula meet these rigorous criteria.

Research to date continues to support comprehensive sexuality education as more effective in reducing sexual risk behaviors, teen pregnancy rates, and STI/HIV infection rates than abstinence-only education (Blake, 2003; Jemmott et al, 1998; Kirby, 2001; Ruiz, 2001; Thomas 2000). Because of the numerous variables related to effectiveness, including replication and fidelity, this research literature does not imply that all comprehensive sexuality education programs are effective. At this time there is not strong scientific evidence that any abstinence-only programs have had similar significant and lasting effects. (Hauser, 2004; Kirby, 2002). For example, a review of publicly-available state-funded evaluation reports on federally-funded Title V abstinence education programs conducted by Advocates for Youth concluded the reports show little evidence of long-term impact on sexual attitudes and intentions, and little evidence of success in delaying sex (Hauser, 2004). The report also concluded that some of these evaluation reports show negative impacts on youth's willingness to use condoms or contraception if they did become sexually active.

A large-scale evaluation of abstinence education programs funded under Title V is currently being conducted by Mathematica Policy Research, Inc. A report of first year impacts from four abstinence-only education programs show the programs increased support for abstinence among youth, but the evidence was not clear about whether young people participating in the programs would be more likely to abstain from sexual behavior (Maynard et al, 2005; see **www.mathematica-mpr.com**). The programs had no effect on other outcomes potentially related to teen risk behaviors such as refusal skills or communication with parents. Future reports will assess the longer-term impacts of the programs on sexual abstinence and sexual activity.

Given the evidence, the Institute of Medicine, American Academy of Pediatrics, American Medical Association, the American Public Health Association, the National Education Association, the National Medical Association, the National School Boards Association, the Society for Adolescent Medicine, and other organizations support comprehensive sexuality education and recommend elimination of mandates for abstinence-only and abstinence until marriage programs. The Wisconsin Department of Public Instruction supports comprehensive sexuality education that stresses abstinence from sexual activity but also provides age-appropriate instruction on condoms and contraceptive use.

At this time, there are a number of lists of effective evidence-based STI, HIV, and pregnancy-prevention programs, some of which are listed in Resource 6.5. There are some differences in the curricula that "make the list" as effective or "evidence-based" because of differences in inclusion criteria, evaluation criteria, and other factors. Despite these differences, some curricula repeatedly appear on the lists. Among these are:

- *Becoming a Responsible Teen* (B.A.R.T.) (ETR Associates at **www.etr.org**)
- *Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention* (Select Media at **www.selectmedia.org**)
- *Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention* (Select Media at **www.selectmedia.org**)
- *Safer Choices* (ETR Associates at **www.etr.org**)
- *Making Proud Choices* (Select Media at **www.selectmedia.org**)
- *Reducing the Risk* (ETR Associates at **www.etr.org**)

See Resource 6.5 Lists of Effective Programs

For a variety of reasons districts may choose to broaden their search for a curriculum that best meets the needs of students in their district. Best practices support using a clear set of criteria associated with program effectiveness. Resource 6.6: Characteristics of Effective Programs, developed by Kirby, is a widely disseminated list of criteria. Resource 6.7 is a worksheet that can be used to assess a particular curricula based on the characteristics of effective sexuality education programs.

See Resource 6.6 Characteristics of Effective Programs (Kirby)

See Resource 6.7 Worksheet for Incorporating Ten Characteristics Common to Effective Sex Education Curricula

ACCEPTABILITY

A majority of parents support comprehensive sex education programs for their children in middle and high schools (National Public Radio et al, 2004). According to the national poll, *Sex in America* (National Public Radio, 2004), parents support school-based sexuality education because they believe the class will be helpful to their children, it will be effective in helping teens avoid HIV/AIDS and other sexually transmitted diseases and pregnancy, it will help young people make responsible decisions about sex, and the class will make it easier for parents to talk with their children about sexuality. The survey also found the majority of parents of junior high and high school students believe the following topics are appropriate for sexuality education instruction taught in school:

- Sexually transmitted diseases
- HIV/AIDS
- Pregnancy and birth
- Birth control and other methods of preventing pregnancy
- Abortion
- Use and sources of contraceptives
- Condoms
- Masturbation
- Sexual orientation

Some individuals express concern that teaching young people about sexuality will hasten sexual behavior. There is now significant evidence that educating young people about sexuality does not increase sexual activity (Blake, 2003; Kirby et al, 1994). The CDC and Department of Public Instruction (DPI) recommend that sexuality education and HIV prevention education include content that is age-appropriate, medically accurate, updated periodically to reflect scientific developments, consistent with community standards, and is appropriate for students' developmental levels and cultural backgrounds.

In addition to selecting curricula on the basis of evidence of effectiveness, other criteria must also be considered. Most parents, teachers, and other adults would agree that the following clear messages should be included in the HGD curriculum:

- Abstinence from all forms of sexual intercourse is the best choice for students.
- Decisions about whether or not to be sexually active, and with whom, and when, and how, are best made when an individual and his/her partner fully understand the emotional, physical, and social consequences of the decision.
- Wisconsin statutes consider sexual contact with a person under the age of 16 years of age to be a felony and sexual intercourse with a person 16 or 17 years of age to be a misdemeanor. More specifically, under Wisconsin statutes it is a:
    - Class C felony/2nd degree sexual assault to have sexual contact or intercourse with a person under 16 years old [Wis. Stat. 948.02(2)].
    - Class B felony/1st degree sexual assault to have sexual intercourse with a person under 13 years old [Wis. Stat. 948.02(1)].
    - Class A Misdemeanor to have sexual intercourse with a person under 16 years old [Wis. Stat. 948.09].

CULTURAL COMPETENCE

Many school classrooms are becoming increasingly diverse. Children and youth reflect diversity in race/ethnicity, socioeconomic status, family structure, first language, religion, gender, sexual orientation, and other characteristics. Some, if not all, of these differences will be particularly relevant when discussing human sexuality. There are many definitions of cultural competency, one of which is "the state of being capable of functioning effectively in the context of cultural differences" (Cross et al, 1989). To enhance our ability to teach effectively in classrooms with culturally diverse students, an important step is to become more aware of our own cultural identities and the lens with which we view the world. From this awareness teachers and other school staff can learn about other cultural groups and be better prepared to design and deliver sexuality education in ways that are appropriate, respectful, and meaningful.

To support learning by all students DPI recommends inclusion of all cultural groups in the curriculum, and encourages Wisconsin school districts to include the contributions, images, and experience of diverse cultural groups in instruction and other classroom activities. The following factors can jeopardize the extent to which children feel included and valued as part of a school community.

- **Invisibility**: under-representation of certain groups, which leads to the implication that these groups are of less value, importance, and significance.

- **Stereotyping**: assigning only traditional and rigid roles or attributes to a group, thus limiting the abilities and potential of that group; denying students knowledge of the diversity, complexity, and variations of any group of individuals.

- **Imbalance/selectivity**: presenting only one interpretation of an issue, situation, or group; distorting reality and ignoring complex and differing viewpoints through selective presentation of materials.

- **Unreality**: presenting an unrealistic portrayal of our history and our contemporary life experience.

- **Fragmentation/isolation**: separating issues related to minorities and women from the main body of the text.

- **Linguistic bias**: excluding the role and importance of females by constant use of the generic "he" and sex-biased words.

Source: Wisconsin Department of Public Instruction. Equity and Education from Dealing with Selection and Censorship: A Handbook for Wisconsin Schools & Libraries. (1999).

Culturally Competent Sexuality Education Resources is an annotated bibliography published by SIECUS in 2002 that provides an extensive list of resources (and ordering information) reflecting various cultural groups (including Latinos, African Americans, Asian and Pacific Islanders, Native Americans, Lesbian, Gay, Bisexual and Transgender individuals, and others) related to sexuality. It can be downloaded from the SIECUS website, at **www.siecus.org**.

Several handouts have been provided in this resource packet to assist school districts to be responsive to a culturally diverse world/district/classroom.

Resource 6.8: **Cultural Competence and Human Growth and Development**

Resource 6.9: **Human Growth and Development: Cultural responsiveness to diverse classrooms**

Resource 6.10: **RESPECTFUL: Guidelines for cross-cultural work**

Resource 6.11 **Special Populations: Key Points That Need to be Addressed When Building Effective Human Growth and Development**

REVIEW INSTRUMENTS

A number of resources may serve as useful tools to assist with the review process for curriculum, videos, and websites based on the factors discussed in this section. **Resource 6.12: The Power of Teaching: Characteristics of Effective Prevention Curriculum** provides a concise summary of curriculum content and delivery characteristics developed by Wisconsin educators. The following additional resources will also aid in curriculum review:

Resource 6.13: Curriculum Assessment – the Power of Teaching

Resource 6.14: Health Education Curriculum Review – HECAT Revised

Resource 6.15: DPI Materials Review Assessment Worksheet

Resource 6.16: Video Assessment Form

Resource 6.17: Website Evaluation Criteria

IMPLEMENTATION

Although evaluation research is able to identify curricular programs that are effective when implemented in a certain way with certain populations, most school districts want to know whether these curricula or programs will work with *their* students. There's no easy answer. Implementers are urged to maintain the fidelity of programs, which means maintaining the original program's key behavioral goals, objectives, theory of behavior change on which the program is based, and core components as defined by the original program developers. Replication refers to implementing the original program with new students or participants in a way that maintains the fidelity to the program. In many cases, though, programs must be adapted so that the program better fits the new population or setting yet doesn't compromise the core components.

A common concern is that teachers don't have sufficient time to implement evidence-based curricula. When there are concerns about time constraints to implement a curriculum,

- Consider a different evidence-based curriculum that can be implemented fully given time available;
- Consider creative ways to make time to fully implement the curricula;
- Consider implementation of computer-based interventions;
- Adapt curriculum while retaining core components, including interactive and small group activities;
- Best practices suggest it is important for teachers to be adequately trained in the rationale, methods, and content of the curriculum so it can be delivered comfortably, confidently and with fidelity (Kirby, 2001).

Sensitive Topics. The ways in which issues considered to be sensitive (e.g., contraceptives, abortion, masturbation, and sexual orientation) are addressed requires thoughtful planning, knowledge, and attention to the comfort level of students, teachers, parents and administrators. It is suggested teachers:

- Review district policy to assure that the curriculum content and activities are developed to meet the needs of all students, and are developed with attention to age and developmental appropriateness.
- If problems with content are anticipated, hold a special meeting with parents/guardians to introduce the content. Develop alternative activities for children of parents who exercise their legal right to exempt their children from this class.
- Establish classroom guidelines to assure a supportive and respectful environment For some, putting chairs in a circle or semi-circle can contribute to an atmosphere that encourages interaction and discussion.
- Work with students to develop classroom ground rules or guidelines. Common guidelines include:
    - Treat each other with courtesy and respect.
    - Listen carefully to others.
    - Allow others to speak without interruption.
    - Be supportive of others. No name-calling or put-downs.
    - No question is stupid or wrong.
    - Students have the right to pass during any discussion or activity that involves personal opinions, feelings, or experiences.
- Teachers and other school staff should be familiar with district policy about answering questions.

The following organizations, among others, have resources on sensitive or controversial topics specifically designed for educators:

Gay, Lesbian, and Straight Education Network (GLSEN) - **www.glsen.org**

- See the Educator Library section of the website for curriculum resources.

National School Board Association – **www.nsba.org**

- See NSBA Bookstore.

Resource Center for Adolescent Pregnancy Prevention – **www.etr.org/recapp**

Sexuality Information Council of the United States (SIECUS) - **www.siecus.org**

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Resource 6.1

Wisconsin's Health Education Academic Standards and Human Growth and Development Instruction

Educational reform has pointed out the need for standards to help school districts have a framework and foundation in developing curriculum, improving instruction, and creating quality assessment procedures. When the state health education standards were developed in 1997, the task force believed that if the standards were achieved by a student that student will become health literate. The traits of health literate citizens are that they are critical thinkers and problem solvers, they are self-directed learners, they can communicate effectively, and they are responsible and productive citizens.

The need for young people to develop literacy with respect to human growth and development is crucial to improving the health of the population and is supported in each of the content standards. The seven health education standards listed below (with grade level examples) show human growth and development instruction contributes to achievement.

A. Health Promotion and Disease Prevention: Students in Wisconsin will understand concepts related to personal health promotion and disease prevention.

A student completing an effective human growth and development program will be able to describe the structure and function of the reproductive system of the human body (grade 4), explain the relationship between positive health behavior and prevention of sexually transmitted diseases (grade 8), and analyze how behavior can impact remaining sexually abstinent (grade 12).

B. Healthy Behaviors: Students in Wisconsin will practice behaviors to promote health, prevent disease, and reduce health risks.

A student completing an effective human growth and development program will demonstrate ways to avoid and reduce threatening situations such as being harassed sexually (grade 4), analyze a sexual decision as to its consequences (grade 8) and evaluate the short- and long-term consequences of teen sexual activity (grade 12).

C. Goal Setting: Students in Wisconsin will demonstrate the ability to use goal-setting to enhance health.

A student completing an effective human growth and development program will create a life goal of a successful education and create a short-term and long-term plan to achieve that goal (grade 4), simulate a career goal and show why abstinence will help achieve that goal (grade 8), and analyze how teen pregnancy challenges teens in reaching their goals (grade 12).

D. Decision Making: Students in Wisconsin will demonstrate decision-making skills to enhance health.

A student completing an effective human growth and development program will predict the outcomes of a positive health decision like abstinence (grade 4), analyze how teen pregnancy can affect family members and friends (grade 8), and predict the short- and long-term consequences HIV/AIDS will have on the family, friends, and community if a family member has HIV or AIDS (grade 12).

E. Information and Services: Students in Wisconsin will demonstrate the ability to access valid health information and services.

A student completing an effective human growth and development program will explain how the media influences our decisions related to sexuality (grade 4), analyze the validity of information presented in the media that can affect our sexual decisions such as statistics related to HIV/AIDS infection (grade 8), and demonstrate the ability to access school and community services to support sexual health (grade 12).

F. Culture, Media, and Technology: Students in Wisconsin will analyze the impact of culture, media, technology, and other factors on health.

A student completing an effective human growth and development program will explain how family discussion about sexual issues influences positive health choices (grade 4), analyze how culture influences attitudes and behaviors surrounding abstinence (grade 8), and evaluate the impact of popular media on our sexual decisions (grade 12).

G. Communication: Students in Wisconsin will demonstrate the ability to use effective interpersonal communication skills to enhance health.

A student completing an effective human growth and development program will demonstrate healthy ways to communicate feelings with good friends (grade 4), demonstrate strategies to communicate personal values (grade 8), and demonstrate ways to communicate care, consideration, and respect in dating situations (grade 12).

H. Advocacy: Students in Wisconsin will demonstrate the ability to advocate for personal, family, school, and community health.

A student completing an effective human growth and development program will identify groups that provide opportunities to socialize in safe, age-appropriate and engaging ways (grade 4), identify barriers to remaining abstinent (grade 8), and demonstrate skills to effectively advocate for abstinence as a positive health choice (grade 12).

The Wisconsin health standards are benchmarked at grades 4, 8, and 12. Grade 12 performance indicators serve only as exit level knowledge, performance, or proficiencies that a young person must achieve when they exit state schools. There is no reason that some of these performance indicators couldn't be placed at an earlier grade level to fit into a school district curricular framework in human growth and development.

The value of human growth and development instruction as part of a comprehensive school health curriculum is clearly a goal that is supported by the State of Wisconsin Health Education Standards. A sound human growth and development curriculum is a valuable part of building the 21st century health literate citizen.

For more information contact Jon Hisgen, Health Education and Physical Activity Consultant, at 608/267-9234 or jon.hisgen@dpi.state.wi.us.

Resource 6.2

Wisconsin's Model Academic Standards for Family and Consumer Education and Human Growth and Development Instruction

Families play a critical role in the cognitive, social, emotional, physical, and brain development of members throughout life. It is in the family that children and youth learn to function confidently in the world. For example, young people

- learn to relate to, care about, and help others;
- build interpersonal communication skills;
- develop planning, problem-solving, and decision-making skills; and
- form character and moral/ethical values as guidelines for behavior.

The academic standards for Family and Consumer Education (FCE) are formulated to support and complement the role of the family in nurturing members' growth and development. These standards focus on the qualities needed to become caring, productive, responsible, and contributing members of society and can be used in conjunction with standards in health education to develop health literacy about human growth and development for the twenty-first century.

Listed below are six Family and Consumer Education content standards that show how human growth and development instruction at three different levels of study might contribute to meeting the *Wisconsin's Model Academic Standards for Family and Consumer Education*. Because of variations in what, how much, and when core concepts in Family and Consumer Education are introduced to students in Wisconsin schools, the standards are not grade specific.[1] Rather, the standards indicate expectations of what students will do to show they have met content standards at introductory (by end of 6th grade), intermediate (by end of 8th grade), and advanced levels of study (by end of 12th grade).

[1] Middle school and high school Family and Consumer Education programs often contain a combination of required and elective courses, and with few exceptions, family and consumer education programs begin in middle school not elementary school. Consistent with the national standards on human development (NASAFCS, 1998), *Wisconsin's Academic Standards for Family and Consumer Education* (1997), are based on an instructional program that accommodates individual differences in learning needs and talents of all students. Thus, depending on students' prior knowledge, background, and experience, some of the performance indicators could be placed at earlier grade levels to fit into a school district's curricular framework for human growth and development. For more information contact Sharon Strom, DPI Consultant-FCE/FCCLA, sharon.strom@dpi.state.wi.us or (608) 267-9088.

Standard A: CONTINUING CONCERNS OF THE FAMILY – Students in Wisconsin will understand the meaning and significance of the broad, continuing concerns of the family.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** *explain the importance of open communication with family members about personal growth and developmental issues.*
- **Intermediate:** *analyze how culture and media influence development of gender roles and gender stereotyping or attitudes toward disability.*
- **Advanced:** *critically examine probable consequences and risks associated with premature sexual activity, cohabitation, or unprotected sex.*

Standard B: PRACTICAL REASONING – Students in Wisconsin will understand and use practical reasoning skills to address broad, continuing concerns of the family.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** explain how practical reasoning is used to address individual, family, or community concerns, such as questions about establishing, maintaining, or improving intergenerational communication.
- **Intermediate:** form sound conclusions about what should be done in specific situations, such as interpersonal conflict situations between parents and children portrayed in various media.
- **Advanced:** use practical reasoning to investigate individual, family, or community concerns, such as questions about forming positive interpersonal relationships with siblings, friends, dates, parents, mentors, work supervisors and teachers.

Standard C: FAMILY ACTION – Students in Wisconsin will understand and use reasoned action (communication, reflection, and application of technical information, methods, and tools) to address broad, continuing concerns of the family and to accomplish family goals.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** *practice interpersonal communication skills in the classroom and other social settings.*

- **Intermediate:** *establish constructive patterns of communication within the family about human sexuality and responsible life choices; reflect upon the consequences of lifestyle choices on oneself and others.*

- **Advanced:** *as input into the selection of potential individual, family or community action projects, conduct local focus groups to identify leading teen health concerns about different aspects of human growth and development, implement action plans to address selected concerns, and evaluate results (see project plan on page 17 of the model academic standards booklet).*

Standard D:PERSONAL AND SOCIAL RESPONSIBILITY – Students in Wisconsin will assume responsibility as family members and citizens, and take informed, socially responsible individual, family, and community action.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** *apply citizenship values (respect and responsibility); work cooperatively to resolve school-related problems, such as bullying, mobbing, physical or verbal abuse.*

- **Intermediate:** *show how to handle pressures to be sexually active consistent with respecting oneself and others.*

- **Advanced:** *plan, implement, and evaluate results of an individual, family or community action plan to address social issues such as a peer education program on prevention of date rape, teen pregnancy, child/domestic abuse, or HIV/AIDS.*

Standard E: WORK OF FAMILY – Students in Wisconsin will understand and actively use specific knowledge, attitudes, and skills related to creating conditions in the family and society to accomplish the work of family goals.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** *identify individual, family, and community goals related to self-development such as building and maintaining trust and other developmental assets.*

- **Intermediate:** *access, analyze, evaluate, and communicate about sources of information on human growth and development (HGD); create a PowerPoint® presentation, skit, public service announcement, display/exhibit, or children's story about some aspect of HGD; for example, produce a PSA on shaking baby syndrome, SIDS, or the effects of alcohol on fetal brains.*

- **Advanced:** *design a child care discovery environment that supports early childhood brain development with attention to the physical, cognitive, social, and emotional.*

Standard F: LEARNING TO LEARN – Students in Wisconsin will reflect on their thinking, manage learning tasks, evaluate their work, monitor their progress and attitudes toward learning, and set new learning goals.

Students completing an effective human growth and development program in Family and Consumer Education will:

- **Introductory:** *make simple plans for reaching learning goals such as developing refusal skills or staying safe and avoiding danger (see illustrative project plan on page 16 of the model academic standards booklet).*

- **Intermediate:** *set personal learning goals related to accomplishing adolescent developmental tasks, such as forming positive relationships or developing a set of ethical principles to guide personal behavior.*

- **Advanced:** *plot a time/life line to show meaningful life goals based on an assessment of personal strengths, areas that need improvement, and priorities.*

Resource 6.3

MPS Scope and Sequence of K-12 HGD Curriculum Concepts

The Advisory Board for Human Growth and Development surveyed parents of Milwaukee Public Schools students to ask at what grade levels they wanted their children to be introduced to the following concepts. After a concept is briefly introduced at a specific grade level, it is expected that learning opportunities at older grade levels will enhance and deepen the student's understanding of the concepts. Introduction and expansion of concepts are based on the intellectual, emotional and social maturity of the students. The Advisory Board took the parents' direction and educational research into consideration as they chose the following grade level applications of the concepts for the curriculum. To understand how the concepts is introduced and at what depth, look to the specific lesson plans for the corresponding grade level.

Concepts	K-1	2-3	4	5	6	7-8	H.S.
Human Development Reproductive anatomy and physiology	I						
Reproduction			I				
Puberty			I				
Body image	I						
Sexual identity and orientation			I				
Relationships Families	I						
Friendship	I						
Dating			I				
Marriage and lifetime commitments				I			
Adoption		I					
Raising children			I				
Personal Skills Values	**I**						
Decision-making	I						
Communication	I						
Assertiveness	I						
Negotiation	I						
Looking for help	I						
Sexual behavior Abstinence			I				
Shared sexual behavior			I				
Masturbation			I				
Human sexual response				I			
Sexual dysfunction				I			
Sexual Health Contraception				I			
Pregnancy Options				I			
Sexually transmitted infections, HIV			I				
Sexual abuse	I						
Reproductive health/hygiene			I				
Society and Culture Gender roles		I					
Sexuality and the law			I				
Sexuality and religion			I				
Cultural Diversity	I						
Sexuality and the media			I				

Resource 6.4

Oconomowoc Area School District's HGD Scope and Sequence

This section of Oconomowoc Area School District's Human Growth and Development Curriculum (1996) Scope and Sequences illustrates the Introduction of Concept (I) and Development of Concept (D).

Human Sexuality–Hygiene

Learner Expectations:	K	1	2	3	4	5	6	8	10-12
1. The student will learn that personal responsibility for hygiene promotes health and well being.	I	D	D	D	D	D	D	D	
2. The student will learn which daily habits are needed for good hygiene.	I	D	D	D	D	D	D	D	
3. The student will realize that personal hygiene enhances self-concept, shows respect for others, and increases the respect others have for you.	I	D	D	D	D	D	D	D	

Human Sexuality–Naturalness of Sexuality

Learner Expectations:	K	1	2	3	4	5	6	8	10-12
1. The student will recognize that sexuality is an important part of one's physical, emotional, and social development.					I	D	D	D	
2. The student will recognize that having sexual thoughts and feelings is common.					I	D	D	D	

Human Sexuality–Pregnancy Risks

Learner Expectations:	K	1	2	3	4	5	6	8	10-12
The student will identify risks involved with teenage pregnancy including premature birth, smaller babies, and poor diet.								I	D

Resource 6.5

Lists of Effective Programs

Below is a list of websites and online documents that discuss the research and literature on evidence-based and promising HIV, STI, and teen pregnancy prevention programs. This list is not intended to be an inventory of all available online resources and we encourage you to search and add to this list. Inclusion of a program or resource does not imply endorsement by the DPI.

Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project. (1999). ***Compendium of HIV Prevention Interventions with Evidence of Effectiveness.*** Atlanta, GA: Centers for Disease Control and Prevention, November, 1999. Revised August 31, 2001. Available at **www.cdc.gov/hiv/projects/rep/compend.htm**

D. Kirby, ***Emerging Answers. Research Findings on Programs to Reduce Teen Pregnancy***. National Campaign to Prevention Teen Pregnancy. Washington, D.C. (2001). **www.teenpregnancy.org/resources/data/report_summaries/emerging_answers/**

J. Manlove, K. Franzetta, K. McKinney, A.R. Papillo, & E. Terry-Humen. ***No Time to Waste. Programs to Reduce Teen Pregnancy Among Middle School-Aged Youth***. National Campaign to Prevent Teen Pregnancy. Washington, DC. (2004). Available at **www.teenpregnancy.org/works/pdf/NotimetoWaste.pdf**

J. Manlove, A.R. Papillio, & E. Ikramullah. ***Not Yet: Programs to Delay First Sex Among Teens***. National Campaign to Prevent Teen Pregnancy. Washington, DC (2004). Available at **www.teenpregnancy.org/works/pdf/NotYet.pdf**

Program Archive on Sexuality, Health, and Adolescence. Los Altos, CA: Sociometrics Corporation. PASHA. (2002). Available at **www.socio.com/pasha.htm**

Resource Center for Adolescent Pregnancy Prevention (ReCAPP). **www.etr.org/recapp/programs/index.htm**

J. Solomon & J.J. Card. ***Making the List: Understanding, Selecting, and Replicating Effective Teen Pregnancy Prevention Programs***. The National Campaign to Prevent Teen Pregnancy. Washington, DC (2004). Available at **http://teenpregnancy.org/works/pdf/MakingTheList.pdf**

Resource 6.6

Kirby's Characteristics of Effective Curriculum-Based Programs to Reduce Teen Pregnancy

Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, by Douglas Kirby, Ph.D., identified programs that increased age of first sex, improved use of condoms or contraception among sexually active teens, and/or reduced teen pregnancy. Common characteristics among the effective curriculum-based programs are identified below.

Effective curriculum-based programs:

1. Have a specific, narrow focus on behavior.
2. Are based on theoretical approaches that have been effective in influencing other risky health-related behavior.
3. Provide clear messages about sex and protection against STDs or pregnancy.
4. Provide basic, not detailed, information.
5. Address peer pressure.
6. Teach communication skills.
7. Include activities that are interactive.
8. Reflect the age, sexual experience and culture of the young people in the program.
9. Last longer than several hours.
10. Carefully select leaders and train them.

What this means is…

- Implement programs that have been demonstrated to be effective with other youth in other places.
- When this is not possible, select or design programs that incorporate these characteristics.
- Each of these characteristics appears to be necessary for the program to be effective.

Source: The National Campaign to Prevent Teen Pregnancy. **Science Says: Characteristics of Effective Curriculum-Based Programs**. Number 4, September 2003.

More Information about the Common Characteristics of Effective Curricula

Source: The following excerpt is from D. Kirby. ***Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy***. National Campaign to Prevent Teen Pregnancy. Washington D.C, May 2001.

The ten characteristics appear to be necessary characteristics–that is, when evaluated programs lacked one or more of these characteristics, they were typically found to be ineffective at changing behavior. However, there is little evidence specifying which of these factors or combinations of factors contributes most to the overall success of the programs.

1. Effective programs focused on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection. These programs focused narrowly on a small number of specific behavioral goals, such as delaying the initiation of intercourse or using condoms or other forms of contraception; relatively little time was spent addressing other sexuality issues, such as gender roles, dating, or parenthood. Nearly every activity was directed toward the behavioral goals.

Few studies evaluated the impact of a focused and potentially effective curriculum unit that was embedded in a larger more comprehensive sexuality education program. Such units may or may not effectively change behavior, but only additional research will answer this question.

2. Effective programs were based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors– such as social cognitive theory (Bandura, 1986), social influence theory (McGuire, 1972), social inoculation theory (Homans, 1965), cognitive behavioral theory (Bandura, 1986; Schinke et al., 1981), theory of reasoned action (Fishbein & Ajzen, 1975) and theory of planned behavior (Ajzen, 1985). These theories together address many of the individual sexuality-related antecedents identified in Chapter 2. They recognize the fact that the beliefs and values of youth are influenced directly through education by parents, schools, and others, and indirectly through observing the behavior of others and the consequences that befall them. In additional, social influence theories address societal pressures on youth and the importance of helping young people understand those pressures and resist the negative ones. Thus, these programs strive to go far beyond the cognitive level; they focus on recognizing social influences, changing individual values, changing group norms and perceptions of those norms, and building social skills.

These theories help to specify which particular antecedents the interventions are trying to change (e.g., the beliefs, attitudes, norms, confidence, and skills related to sexual behavior), so that changes in these antecedents would lead to voluntary change in sexual or contraceptive behavior. Thus, each activity was designed to change one or more antecedents specified by the particular theoretical model for the curriculum, and each important antecedent in the theoretical model was addressed by one or more activities. While all of the effective curricula focused on antecedents specified by their adopted

theories, some program developers actually surveyed students and empirically determined which possible antecedents best predicted desired behavior. Activities in their programs then focused on those particular antecedents.

By focusing on specific behavior (characteristic #1), by identifying particular antecedents causally related to that behavior, and by designing activities to change each of those important antecedents, the developers of these programs were, in fact, designing "logic models" and basing their interventions on those models (Kirby, 2000). Logic models are discussed in Chapter 6.

3. Effective programs gave a clear message about sexual activity and condom or contraceptive use and continually reinforced that message. This particular characteristic appeared to be one of the most important criteria that distinguished effective from ineffective curricula. The effective programs did not simply lay out the pros and cons of different sexual choices and implicitly let the students decide which was right for them; rather, most of the curriculum activities were directed toward convincing the students that abstaining from sex, using condoms consistently, or using other forms of contraception consistently was the right choice, and that unprotected sex was clearly an undesirable choice. To the extent possible, they tried to use group activities to change group norms about what was the expected behavior.

4. Effective programs provided basic, accurate information about the risks of teen sexual activity and about methods of avoiding intercourse or using protection against pregnancy and STDs. Effective programs provided basic information that students needed to assess risks and avoid unprotected sex. Typically, this information was not detailed or comprehensive. For example, the curricula did not provide detailed information about all methods of contraception or different types of STDs. Instead, they provided a foundation: they emphasized the basic facts needed to persuade youth to avoid unprotected sex, and they provided information that would lead to changes in beliefs, attitudes, and perceptions of peer norms. Some curricula also provided more detailed information about how to use condoms correctly.

5. Effective programs included activities that address social pressures that influence sexual behavior. These activities took a variety of forms. For example, several curricula discussed situations that might lead to sex. Most of the curricula discussed "lines" that are typically used to get someone to have sex, and some discussed how to overcome social barriers to using condoms (e.g., embarrassment about buying condoms). Some of them also addressed peer norms about having sex or using condoms. For example, some curricula provided data showing that many youth *do not* have sex or *do* use condoms, or they had students engage in activities in which they concluded that students should abstain from sex or use condoms and then expressed those beliefs to other students. At least one curriculum addressed media influences (e.g., how sex is used to sell products and how television often depicts characters having unprotected intercourse but rarely experiencing negative consequences).

6. Effective programs provided modeling of and practice with communication, negotiation, and refusal skills. Typically, the programs provided information about skills, demonstrated the effective use of those skills, and then provided some type of skill rehearsal and practice (e.g., verbal role-playing and written practice). Some curricula taught different ways to say "no" to sex or unprotected sex, how to insist on the use of condoms or other methods of contraception, how to use body language that reinforced the verbal message, how to repeatedly refuse sex or insist on condom use, how to suggest alternative activities, and how to help build the relationship while refusing unprotected sex or refusing to have sex at all. Some curricula started with easier scenarios in role-playing and then moved to more challenging ones. Some started with fully scripted role plays and moved to more improvisational ones, in which the youth resisting unprotected sex had to use their own words. Although all effective curricula gave some attention to skills, there were significant variations in the quality of activities designed to teach skills and also in the time devoted to practicing the skills.

7. Effective programs employed a variety of teaching methods designed to involve the participants and have them personalize the information. Instructors reached students by engaging them in the learning process, not through didactic instruction. Students were involved in numerous experiential classroom and homework activities, such as small group discussions, games or simulations, brainstorming, role-playing, written exercises, verbal feedback and coaching, interviewing parents, locating contraception in local drugstores, and visiting or telephoning family planning clinics. In addition to these experiential activities, a few effective curricula used peer educators or videos with characters (either real or acted) who resembled the students and with whom the students could identify. All of these activities kept the students more involved in the program, got them to think about the issues, and helped them personalize the information in their own lives.

8. Effective programs incorporated behavioral goals, teaching methods, and materials that were appropriate to the age, sexual experience, and culture of the students. For example, programs for younger youth in junior high school, few of whom had engaged in intercourse, focused on delaying the onset of intercourse. Programs designed for high school students, some of whom had engaged in intercourse and some of whom had not, emphasized that students should avoid unprotected intercourse; that abstinence was the best method of avoiding unprotected sex; and that condoms or contraception should always be used if they did have sex. And programs for higher-risk youth, most of whom were already sexually active, emphasized the importance of always using condoms and avoiding high-risk situations. Some of the curricula, such as *Becoming a Responsible Teen* and *Making a Difference*, were designed for specific racial or ethnic groups and emphasized statistics, values, and approaches that were tailored to those groups.

9. Effective programs lasted a sufficient length of time to complete important activities adequately. In general, it requires considerable time and multiple activities to change the most important antecedents of sexual risk-taking and to thereby have a real influence on behavior. Thus, short programs that lasted only a couple of hours did not

appear to be effective, while longer programs that had many activities had a greater effect. More specifically, effective programs tended to fall into two categories: (1) those that lasted 14 or more hours and (2) those that lasted a smaller number of hours but recruited youth who voluntarily participated and then worked with these youth in small group settings with a leader for each group. (When youth volunteer to participate, they may be more open to instruction than if they are required to sit in a school class. And when they work in small groups, instructors may be able to involve the youth more completely, to tailor the material to each group, and to cover more material and more concerns more quickly.)

10. Effective programs selected teachers or peer leaders who believed in the program they were implementing and then provided them with training. Given the challenges of implementing programs that focused on a sensitive topic and incorporated a variety of interactive activities, the effective programs carefully selected teachers and provide them with training. The training ranged from approximately six hours to three days. In general, the training was designed to give teachers and peer leaders information on the program as well as practice using the teaching strategies included in the curricula (e.g., conducting role-playing exercises and leading group discussions). Some of the teachers in these effective programs also received coaching and/or follow-up training to improve the quality of their teaching.

Resource 6.7

Worksheet for Incorporating Ten Characteristics Common to Effective Sexuality Education Curricula[1,2]

Think about a sexuality education program (or sexuality education program component) that you have implemented, are implementing, or are planning to implement.

- In what ways and to what extent does this sexuality education program incorporate each of the ten characteristics common to effective sexuality education curricula?
- How could you strengthen incorporation of these characteristics?

Characteristic:	***1. Address social pressures that influence sexual behavior (e.g., situations that might lead to sex, embarrassment about buying condoms, peer pressure, media influence).***
*Example from **Reducing the Risk**, an empirically-validated program:*	Through a class discussion and mini-lecture, participants identify "yellow-alert" and "red-alert" situations that can lead to unwanted or unprotected sex. They then fill out the worksheet "Handling Crisis Situations," which has them develop plans to manage the situations.
What our curriculum currently does:	

[1] The ten characteristics are drawn from D. Kirby. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy.* National Campaign to Prevent Teen Pregnancy. Washington, D.C. (2001)

[2] Examples from the *Reducing the Risk* program are drawn from the following sources: R.P. Barth, R.P. *Reducing the Risk: Building Skills to Prevent Pregnancy, STD, and HIV*, 3rd ed. ETR Associates. Santa Cruz, CA (1996). J.J. Card, S.R. Becker, & D.M.K. Hill. *The PASHA Program Sourcebook: Promising Teen Pregnancy and STD/HIV/AIDS Prevention Programs*. Sociometrics Corporation. Los Altos, CA (1998), Chapter 3. D. Kirby, R.P. Barth, N. Leland, & J. V. Fetro. Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking. *Family Planning Perspectives.*, (1991), 23(6), 253-63.

What else could be done:	

Characteristic:	***2. Employ a variety of teaching methods designed to involve the participants actively and have them personalize the information (e.g., small group discussions, role playing, peer educators).***
*Example from **Reducing the Risk**, an empirically-validated program:*	The curriculum includes extensive teacher modeling of desirable skills and behaviors, coupled with participant role-playing to practice these skills and behaviors. For example, in one role-play, participants form dyads in which one uses "lines" to try to convince the other to engage in sexual activity, and the other responds with appropriate refusal statements.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***3. Incorporate behavioral goals, teaching methods, and materials appropriate to the age, sexual experience, gender, and cultural and linguistic background of participants.***
*Example from **Reducing the Risk**, an empirically-validated program:*	The program targets high school students with varying levels of sexual experience, and therefore promotes both abstinence and use of contraception under the umbrella message of avoiding unprotected intercourse. The teaching methods address the social pressures that high school students face and afford them practice in using communication and refusal skills in age-appropriate and realistic situations (e.g., parties, pharmacies, conversations with friends, etc.)
What our curriculum currently does:	
What else could be done:	

Characteristic:	***4. Model and afford practice in communication, negotiation and refusal skills (e.g., role-playing how to say "no" to sex or how to insist upon condom use).***
*Example from **Reducing the Risk**, an empirically-validated program:*	Participants learn delay statements and alternative actions—that is, how to avoid risky situations or to delay taking action until they can decide what to say/do or until they are prepared to implement a decision. They also learn to say "no" in a way that maintains a good relationship but leaves no ambiguity about the intention to abstain from sex or unprotected intercourse. For example, in one activity, participants watch a demonstration of social skills that are important to abstaining and using protection. Then they practice five characteristics of effective refusals: saying "no," repeating the refusal, suggesting alternatives, using body language that says "no," and building the relationship (if appropriate).
What our curriculum currently does:	
What else could be done:	

Characteristic:	***5. Give a clear message about sexual activity and condom or contraceptive use and continually reinforce that message.***
*Example from **Reducing the Risk**, an empirically-validated program:*	The program explicitly and repeatedly emphasizes throughout the curriculum that students should avoid unprotected sex, either by not having sex or by using contraceptives.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***6. Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding it.*** *Note: Increasing knowledge was not the primary goal of the effective curricula, but basic facts needed to make behaviorally-relevant decisions and changes in beliefs and attitudes were provided.*
*Example from **Reducing the Risk**, an empirically-validated program:*	The curriculum provides accurate information about the means of avoiding pregnancy and HIV. In particular, it discusses the particular advantages of abstinence, but also provides information on condoms and contraception, including visual demonstrations of different methods and information on where to obtain them.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***7. Last a sufficient length of time to complete important activities adequately.*** *Note: Effective programs tended to last 14 hours or more or be implemented in small group settings. Single-session interventions are rarely effective.*
*Example from **Reducing the Risk**, an empirically-validated program:*	16 lessons or classes designed for 45-minute class periods, plus homework assignments.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***8. Select teachers or peers who believe in the program and provide training for them in both the materials and methods of the curriculum.*** *Note: Training for effective programs ranged from six hours to three days.*
*Example from **Reducing the Risk**, an empirically-validated program:*	In the original implementation and evaluation of *Reducing the Risk*, teachers who implemented the program first participated in a three-day training session. The training focused primarily on giving teachers the opportunity to practice role-playing and other class activities. A detailed teacher's handbook is part of the *Reducing the Risk* curricular materials. In addition to being a curricular guide, it includes information on critical issues regarding state and district laws, parental consent, ground rules for classroom discussion, and strategies for effective role-plays.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***9. Focus on changing a small number of sexual behaviors that lead to unintended pregnancy/STD/HIV/AIDS.*** *Note: Nearly every activity was directed toward the behavioral goals.*
*Example from **Reducing the Risk**, an empirically-validated program:*	Program message focused on reducing the frequency of unprotected sexual intercourse by (1) delaying or reducing the frequency of intercourse and (2) increasing condom/contraceptive practice among those who are sexually active.
What our curriculum currently does:	
What else could be done:	

Characteristic:	***10. Are based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors.***
*Example from **Reducing the Risk**, an empirically-validated program:*	*Reducing the Risk* is based on Social Learning Theory, which says that people learn skills by observing others' behavior and imitating it. According to this theory, the likelihood of engaging in an action (e.g., abstaining or using condoms or contraception) is determined by: (1) Understanding what must be done to avoid pregnancy and STD/HIV (knowledge); (2) Belief that one will be able to use the methods (self-efficacy); (3) Belief that the methods will be successful (outcome expectation); and (4) The benefit one expects from accomplishing the behavior (motivation). Another important tenet of the theory is that people learn skills by observing others' behavior and imitating it. The curriculum is designed to build knowledge of the risks of unprotected intercourse and the means of avoiding it; self-efficacy with respect to abstaining from sex or using contraception; expectancy that these methods will be successful; and motivation to reduce risky sexual behaviors. Teachers and peers model socially desirable behaviors, and participants practice these behaviors through role-playing activities. Participants also practice obtaining birth control information from stores and clinics. This builds their knowledge, sense of self-efficacy, outcome expectation, and motivation.
What our curriculum currently does:	
What else could be done:	

Source: Julie Solomon, Sociometerics Corporation, 2004

Resource 6.8

Cultural Competence and Human Growth and Development

"Cultural competence" is a set of skills that will help you increase your understanding and appreciation of your own and different cultures. The primary goal is to foster a continued process of reflection, practice, and assessment to create curriculum, instruction, and a classroom climate that is culturally responsive. It is important for the human growth and development (HGD) educator as well as the HGD curriculum committee to develop a HGD curriculum that will meet the needs of ALL students in the school.

The HGD committee has to be aware of the factors that contribute to reaching a population that holds different cultural beliefs than those held by the majority of the teachers and students in that district. Some of the cultural factors that are critical in building an effective HGD curriculum are family values and beliefs, the students' perceptions of the topic based on cultural background, and the ability to communicate within their culture as well as in the classroom.

These are some hints that could be helpful to both the HGD committee and the HGD instructors in building "cultural competency" into the HGD curriculum and classroom:

1. Understand that ALL students bring a unique perspective, based on race, ethnicity, gender, socio-economic status, ability, sexual orientation, etc., to the classroom.

2. Understand that different cultures address sensitive subjects differently within the home environment, which could include not addressing the subjects.

3. Understand that different cultures have different family and child-rearing principles.

4. Collaborate with public health personnel that provide services to different communities in your area; they may be a great resource for culturally responsive materials.

5. Seek multicultural training opportunities for yourself and continue the process of building cultural competence in all ways available to you.

6. Support the active involvement of ALL parents as the primary human growth and development teachers of their children.

7. Model willingness to hear ideas different from your own, and encourage students to learn about cultures and how different cultures address HGD issues.

8. Model willingness to face your own misconceptions about various cultures, and encourage students to do the same.

9. Actively apply multiple strategies in HGD instruction.

Resources

Cultural Awareness and Sensitivity: Guidelines for Health Educators
AAHE
1990 Association Drive
Reston, Virginia 22091

A Youth Leader's Guide to Building Cultural Competence
Advocates for Youth
1025 Vermont Avenue, N.W. Suite 200
Washington, D.C. 20005

Source: Milwaukee Public Schools 2003 Human Growth and Development Curriculum

Resource 6.9

Human Growth and Development (HGD):
Cultural responsiveness to diverse classrooms

Becoming Culturally Responsive

Being culturally responsive to diverse classrooms is the mark of a competent and caring professional educator. Building this responsiveness has three parts: exploring your own beliefs and culture, getting to know your students as individuals and not as representatives of their cultural group, and developing culturally responsive curriculum and instruction.

1. Exploring your own beliefs and culture

Often, our cultural ways are so natural to us that we fail to realize that not everyone shares them. These unexamined biases are barriers to working effectively with students who are different from yourself, as surely students in your classroom will be.

Some questions that might begin the process of examining your cultural background and life experiences include[1]:

Acculturation

- If your family immigrated to the United States, how long has your family been here? How long have you been in the United States? Did your family come voluntarily to the United States?
- If you are American Indian, what is your family's history?
- What values, beliefs, customs, traditions, or behaviors have you retained or adopted from your family history? Has that changed over the years?

Citizenship Status

- What is your citizenship status? What is the status of members of your family? What are the reasons behind having or not having U.S. citizenship in your family? Do you or any of your family have dual citizenship?
- Do you or your family members plan to stay in the U.S. or do you or they hope to return to your family's homeland?

Communication

- What language or dialect is spoken in your home? Is it different or similar to the language used in your household growing up? Is there a generational split among your family members with regard to speaking English versus another language?
- Are there certain non-verbal signals that you consider polite or rude, such as eye contact, physical closeness, or tone of voice?
- Do children or teens in your family have the same rights to speak as adults?

[1] From SA Messina, A Youth Leader's Guide to Building Cultural Competence (Washington, D.C.: Advocates for Youth, 1994).

Family

- What is your family structure? Who is considered to be a member of your family? Are there individuals who are not blood relatives but who are considered family such as longtime friends, neighbors, or godparents?
- What are/were the expectations of what responsibilities you have to your parents or family? What responsibilities did/do your parents and other family members have to you?
- Are there any openly gay, lesbian, bisexual or transgender members of your family, including you? Are they acknowledged? Accepted?

Gender

- Did your family encourage both yourself and members of the other sex to stay in school? Play sports? Help at home? Be assertive? Go to college? To work outside the home?
- Did your family expect either males or females to be more knowledgeable, interested or experienced in dating, sex, parenting, or wage-earning? Were you allowed to socialize in co-ed groups? Is one gender supposed to be more interested in monogamy or abstinence before marriage?

Health and Safety

- How is illness treated in your family? Do certain behaviors or beliefs play a role in illness? What behaviors or remedies were used to prevent or cure illness?
- Are emotional, mental, physical, and spiritual factors included in your definition of health?
- When and how do you seek medical treatment? Do you have medical insurance?
- What is the degree of violence in your community? How has that had an impact on you?

Poverty and Economic Concerns

- What was the standard of living in your family when you were growing up?
- Have you or your family members ever received public assistance? How has that influenced your perspectives?

Race and Ethnicity

- What races and ethnicities are represented in your family? How often do you think about your race or ethnicity?
- How has the United States treated people of similar race and ethnicity to you and your family? What laws and policies have affected people of similar race and ethnicity to you?

Sexual Orientation

- What is your sexual orientation? Are you gay, lesbian, bisexual or transgender? If yes, when did you come out to yourself? Are you out to friends? Family? Employers and co-workers? Why or why not?
- How have people of similar sexual orientation been treated by our society? How has that had an impact on you?

2. Getting to know the young people in your program as individuals and not as representatives of their cultural group[2]

As a caring adult who works with youth, you already know how important it is to become acquainted with the unique personalities of each young person in your classroom. You know that every teenager has his or her own likes, dislikes, experiences, sense of humor, ambitions, attention span, skills, personal style and family situations. A big part of the fun of working with a group of young people is getting to know them as individuals and working with the diversity they bring to the group.

As you focus on building cultural competence, be sure that you *continue* to view the young people in your program as individuals. Beware of the temptation to quickly explain behavior as the result of culture. Do not expect any individual student to be the ambassador for their racial or ethnic group or to be able to explain the group's entire range of cultural beliefs.

3. Developing culturally responsive interactions, curriculum and instruction, and classroom climate

Being colorblind is not the answer! Culturally responsive teaching demonstrates the teacher's commitment to his or her students because the teacher recognizes that race, ethnicity, class, gender, ability, sexual orientation, and other factors influence how students learn. It is critical to create a curriculum and teach students in a way that honors and shares these different influences. One manifestation of the teacher's commitment is to design curriculum and instruction with input and attention to as many of the cultural factors as possible.

It may not be possible for you to learn in depth about every one of the cultural components that are represented in your students. Focus your efforts on learning what is most important to know about the specific cultural backgrounds from which your students come. Working on HGD, you already know that you will want to concentrate on cultural beliefs, attitudes, and behaviors about sexuality, gender roles, communication, health, families and children.

You will want to pay particular attention to issues around poverty and money, which are often "hidden" cultural factors. Research indicates that the sexual behaviors that put young people at risk for HIV/AIDS and unwanted pregnancy are tied to what teens see in their future, which corresponds often to socio-economic status. To provide your students with culturally responsive and useful information related to HGD, consider providing information on the availability of low- or no-cost contraception, including condoms, and the availability of community resources for medical, housing and other assistance for your students and their families.

[2] From SA Messina, A Youth Leader's Guide to Building Cultural Competence (Washington, D.C.: Advocates for Youth, 1994).

Strategies for Building Cultural Competence[3]

As a teacher who cares about cultural competence, you want to provide students with effective programs that engage them, speak to their cultural experience, reinforce positive health messages received at home and help them be comfortable with their racial, ethnic, gender, ability, sexual orientation, and other identities. Some tips for doing that include:

1. Find the cultural beliefs and practices that reinforce the attitudes and skills your program seeks to build. Be creative and accurate in using traditions that can inform and shape a variety of program activities.
2. Include guest speakers or volunteers who share the same race, ethnic, gender, ability, socio-economic, sexual orientation, etc., background as students. Have both men and women involved in your classroom.
3. Assume there is a wide range of views, particularly about sexuality issues, in your classroom. Understand how some of the HGD messages might be the same as, or different from, family values and practices.
4. Model willingness to hear and accept ideas different from your own.
5. Encourage the involvement of your teens' family members in classroom curriculum and activities.
   - Reach out to families. Plan family-based experiences during hours convenient for families.
   - In planning family involvement, however, bear in mind that not all families show involvement in the same way that you would show family involvement.
6. Make sure that activities, discussions, videos, written materials, and guest speakers reflect the cultural and ethnic diversity of the students, the community and society in general. Choose wisely: a terrific video featuring urban African American teens would be an excellent selection for urban African American teens, but may be inappropriate for a middle class suburban African American group.
7. Build alliances across student groups by using structured and purposeful activities. Mix students up in teams and partnerships and have them work together to reach a common goal.
8. Support young people's exploration of their ethnic and racial identity.
   - Help young people understand that loyalty to one group does not mean disloyalty to another. Ethnic or racial pride does not mean rejection of other groups. Bi- and multi-racial teens, in particular, need help in this area.
   - Recognize the power of your influence on the students in your classroom and be mindful of biases you might have about what identities teens should assume.
9. Support young people's sexual orientation.
   - Learn about the range of issues related to teens and sexual orientation. Seek further resources if this topic is unfamiliar.
   - Know that it is highly likely that some young people in your classroom may identify themselves as gay, lesbian, bisexual, or transgender. Understand that they may **or may not** have engaged in same-gender sexual behavior; a lesbian, gay, bisexual, or transgender orientation involves more than just sexual identity.

[3] From SA Messina, A Youth Leader's Guide to Building Cultural Competence (Washington, D.C.: Advocates for Youth, 1994).

- Make your classroom a safe place for lesbian, gay, bisexual, and transgender young people by ensuring that disrespectful language and comments are not allowed to pass unchallenged.
- Know what community resources exist to support lesbian, gay, bisexual, and transgender youth.

10. Engage young people in open and on-going dialogues regarding stereotypes, bias and discrimination and the limits they impose.
11. Seek multicultural training opportunities for yourself and continue the process of building cultural competence in all ways available to you.

Developed by Courtney Reed Jenkins, Gender Equity Consultant, WI Department of Public Instruction (July 2001).

Resource 6.10

RESPECTFUL: Guidelines for Cross-Cultural Work

One model to increase one's awareness of various aspects of identity and culture is represented by the acronym **RESPECTFUL**. The model was developed by Dr. Michael D'Andrea of the University of Hawaii to help us understand the complexities of identity and help us avoid stereotypes associated with cultural identities. For this HGD Resource packet the model has been adapted by adding questions linking aspects of identity with aspects of sexuality and sexuality education. For teachers of all children, the acronym serves as a reminder of the complexity of each child's identity. For teachers of high school students, the acronym may serve as a basis for discussion around identity and sexuality.

R – Religious and Spiritual Orientation
- What does a person believe about the world? What are the important religious and spiritual beliefs and how do they relate to personal values related to sexuality?

E – Ethnic/Cultural/Racial Backgrounds
- What identities does an individual claim? How do these identities complement or challenge one's sexual identity? What biases or stereotypes exist?

S – Sexual Identity and Orientation
- How does an individual self identify? How is an individual perceived by others? How are these identities influenced by families of origin? School? Other aspects of culture?

P – Psychological Maturity
- What are common characteristics of the psychological maturity of children or youth a particular age? What is hard about being this age? What's good about it?

E – Economic Class Standing
- What is a person's socio-economic status? How does this influence choices and decisions and consequences?

C – Current Chronological Challenges
- What are the challenges common to middle school students? High school students? What's great about being this age?

T – Threats to Personal Wellness
- What factors threaten one's health and wellness? How do certain sexual behaviors support or threaten a person's health?

F – Family History and Influence
- How would you describe your family? What are important messages about sexuality you get from your family?

U – Unique Physical Characteristics
- How do you take care of your body? What's great about your body?

L - Location/Language
- Where is a student from and what language(s) does he/she use at home? With friends?

Source:
RESPECTFUL Guidelines for Cross-Cultural Work from National Clearinghouse for Bilingual Education list-serve and adapted by N. Smith Cox.

Resource 6.11

Special Populations:
Key Points That Need to be Addressed When Building
Effective Human Growth and Development

Adapted from the North Star Guide: Edgerton School District's Team Approach to Delivering Functional Skills.

When addressing human growth and development instruction with developmentally disabled students, implement the following procedures and strategies:

1. Develop and implement an age-appropriate, functional service delivery human growth and development model that includes appropriate integration and connections to the community.
2. Provide adequate staff development that emphasizes appropriate content and teaching strategies for the moderate/severely disabled in the regular education setting.
3. Promote quality planning time, problem solving, and teaching strategy time for teams to address students with severe disabilities.
4. Consistently review district programming and delivery services for disabled students.
5. IEPs (Individualized Education Program) should include some reference to human growth and development if relevant to the student.
6. Align the curriculum to national health education standards and appropriate benchmarks based on the disability.
7. Develop alternative standardized or performance assessments depending on the disability.
8. Identify appropriate educational resources for your curriculum.
9. Develop an effective communication strategy to connect to the home environment.
10. Provide parental educational opportunities in human growth and development so they can support their child's experiences in this sensitive area.
11. Create a source of materials on this subject matter for both teachers and parents.
12. Provide a written report of skills that the student did not master or did master as well as skills students are attaining or those skills that need to be dropped.
13. Provide a safe and engaging learning environment for all students.

Resource 6.12

The Power of Teaching: Characteristics of Effective Prevention Curriculum

Curriculum Content Characteristics

1. Accurate and up-to-date information on health promotion and risk behaviors is essential.

2. Normative education is essential in shaping beliefs, attitudes, and behaviors.

3. A strong focus on life skill development is essential.
    - Critical thinking skills
    - Communication skills
    - Stress-management skills
    - Goal-setting skills
    - Advocacy skills

4. Key concepts that cut across many health and safety issues should be emphasized.
    - Influences
    - Consequences
    - Safety
    - Responsibility

Curriculum Delivery Characteristics

1. Multiple instructional strategies are essential.

2. It is better to take more time to teach fewer concepts and skills.

3. Knowledge is the interaction between a student's prior knowledge and new information.

4. A sense of safety and community in the classroom is basic to student learning.

5. Clear and consistent messages are essential.

6. Involvement of parents and guardians in the instructional process is critical.

7. Student learning is assessed.

Source:
Wisconsin Department of Public Instruction. *The Power of Teaching. Characteristics of Effective Classroom Instruction on Health and Safety Issues*. . (2004). Available at **www.dpi.wi.gov/sspw/powerof.html**

Resource 6.13

Curriculum Assessment – Power of Teaching

Curriculum: _____

How would you assess your curriculum based upon the principles of effective classroom instruction described in the Wisconsin Department of Public Instruction's document, *The Power of Teaching*?

Directions: Rate your curriculum by circling the appropriate number (1-5) and add your ratings to get a total score and see if your curriculum has got the POWER!

Characteristic of Effective Classroom Instruction on Health & Safety Issues	**Rating** **Not at all**				**Completely**
	1	**2**	**3**	**4**	**5**
Assessment: Assesses prior student knowledge, attitudes and skills at beginning of instructional unit	1	2	3	4	5
Content: Includes accurate and up-to-date information on health promotion and risk behaviors	1	2	3	4	5
Includes accurate information on norms and strategies to foster correct beliefs about norms	1	2	3	4	5
Includes a strong focus on life skills, including:					
Critical thinking skills (decision-making, problem-solving, etc.)	1	2	3	4	5
Communication skills	1	2	3	4	5
Stress management skills	1	2	3	4	5
Goal setting skills	1	2	3	4	5
Advocacy skills	1	2	3	4	5
Emphasizes key concepts that cut across many health and safety issues, including:					
Influences	1	2	3	4	5
Consequences	1	2	3	4	5
Safety/health promotion	1	2	3	4	5
Responsibility, rules, and boundaries	1	2	3	4	5
Emphasizes a few concepts and skills,	1	2	3	4	5

Characteristic of Effective Classroom Instruction on Health & Safety Issues	Rating Not at all				Completely
but in considerable depth					
Instructional Strategies: Incorporates multiple instructional strategies, including:					
Interactive, hands-on activities	1	2	3	4	5
Cooperative learning	1	2	3	4	5
Self-assessment	1	2	3	4	5
Other strategies	1	2	3	4	5
Provides flexibility for teacher to enhance curricula	1	2	3	4	5
Includes strategies to build safety and community in the classroom	1	2	3	4	5
Includes strategies to reinforce messages in other school and community experiences.	1	2	3	4	5
Involves parents and family	1	2	3	4	5
Authentic student assessment on knowledge and skills	1	2	3	4	5
Access and Implementation: Barriers (cost, need for specialized training, portability, durability of materials) are minimal.	1	2	3	4	5

Total Points: (add rating for each item from both sides)_____

The curriculum...

- 92-115 has many positive curricular issues.
- 69-91 has some positive curricular issues, but may not have everything needed to make this an effective curriculum.
- 46-68 has some definite problems and is in need of revision.
- 23-45 does not fit any of the criteria needed for effective classroom instruction and is in critical need of revision.

Comments:

Resource 6.14

HEALTH EDUCATION CURRICULUM REVIEW ASSESSMENT—HECAT revised

Curriculum Title:

Authors:

Publishers/Date of Publication:

Target Grade Level: **Comprehensive or Topic-specific:**

CRITERIA	ASSESSMENT
For each criterion, find at least one example from the curriculum to support your assessment.	
Part I: PRELIMINARY CURRICULUM CONSIDERATIONS	
Accuracy—Health information is scientifically sound, medically accurate, and current (within 5 years) (1 = Major errors are evident; 2 = Many minor errors; 3 = Only a few minor errors are evident and are easy to correct; 4 = No corrections are necessary)	1 2 3 4
Acceptability—Curriculum addresses health priorities for the community, complements diversity of cultures among students within the community, etc. (1 = Major errors are evident; 2 = Many minor errors; 3 = Only a few minor errors are evident and are easy to correct; 4 = No corrections are necessary)	1 2 3 4
Feasibility—Curriculum can be implemented by most health education teachers and within the available instructional time (1=Not feasible; 4 = very feasible)	1 2 3 4
Affordability—Core curriculum and necessary instructional materials are affordable. (1 = Not affordable or sustainable; 4 = very affordable and sustainable)	1 2 3 4
Curriculum Design— Design, graphics, language are engaging and appropriate Organization of curriculum materials is logical and easy to use Graphics avoid modeling unhealthy behaviors Objectives are clearly identified	1 2 3 4
Research-based and Theory-driven— Curriculum based on theory related to health behaviors Curriculum evaluated as effective with at least one population	1 2 3 4
Comments:	

Part II: CURRICULA CONTENT				
1. Addresses important topics • Addresses priority health education areas (which ones?) • Addresses health education standards (which ones?) • Addresses cognitive, affective, skill domains	1	2	3	4
2. Addresses individual values and group norms that support health-enhancing behaviors. • Provides opportunities for peer support (peer discussions, group problem solving, peer modeling, peer teaching) • Includes activities to influence peer and family support for healthy behaviors (school-wide media campaigns, family involvement) • Includes activities to counter student misperceptions about norms	1	2	3	4
3. Increases personal perception of risk.	1	2	3	4
4. Addresses social pressures.	1	2	3	4
5. Builds personal and social competencies.	1	2	3	4
6. Provides functional knowledge.	1	2	3	4
Part III. INSTRUCTIONAL STRATEGIES				
1. Uses strategies to personalize information and engage students.	1	2	3	4
2. Provides age- and developmentally-appropriate information and learning strategies. • Student-centered, interactive, engaging • Developmentally appropriate • Can meet learning differences of variety of students • Includes strategies to engage parents/caregivers	1	2	3	4
3. Incorporates strategies and materials that are culturally inclusive.	1	2	3	4
4. Provides adequate time for instruction.	1	2	3	4
5. Provides opportunities to reinforce skills. • Additional activities are provided to expand learning outside the classroom (family activities, field trips, etc.)	1	2	3	4
6. Provides background information for teachers and/or makes professional development opportunities available. • Sufficient background information provided for teacher • Clear, step-by-step procedures for facilitation • Essential materials are provided to reduce preparation time	1	2	3	4

HECAT revised – Cox 2005

Resource 6.15

Materials Review Assessment Worksheet

Criteria Met (1=not at all… 5= completely)	**Criteria**	**Comments**
	1. Technically accurateand up-to-date	
	2. Gender fair	
	3. Developmentally appropriate for intended age and ability	
	4. Racially, ethnically, culturally non-biased	
	5. Sound educational methodology for the recommended audiences	
	6. Positive approach to human sexuality	
	7. Educational messages/ strategies for the continuum of risk behaviors	
	8. Resource quality	

Additional Comments:

REVIEW CRITERIA FOR HIV/AIDS INSTRUCTIONAL RESOURCES

Criteria	Definition	Scale or Continuum (1= criteria was not at all met 5= criteria was completely met)
1. Technical accurate and up-to-date	*Information on virus, transmission, protection are complete and accurate to date of publication; information on where to access current data provided.	Automatic rejection if information is inaccurate, incomplete, or outdated.
2. Gender fair	*Equal and appropriate representation of males and females. Demonstrates equality in roles/authority, use of referent pronouns, addressing male and female risks of transmission and responsibility for prevention/protection.	
3. Developmentally appropriate for intended age and ability	*Language, concepts and tone (emotional message) appropriate for age and audience. Addresses the needs of all learners, including those with physical, cognitive or emotional disabilities.	
4. Racially, ethnically, culturally non-biased	*Representation of communities of color and other diverse populations in actors and in materials that recognize and respect ranges in cultural/community norms, language, and beliefs.	
5. Sound educational methodology for the recommended audiences	*Focuses on the affirmation of personal responsibility and decision-making. Skill-based, interactive and creative experience fostered.	
6. Positive approach to human sexuality	*Presents human sexuality as positive. Builds on a basic appreciation of human sexual expression throughout the lifespan, including sexual orientation.	
7. Educational messages/ strategies for the continuum of risk behaviors	*Abstinence from sexual intercourse and injectable drug use are promoted as the only 100% risk-free behaviors for the majority of HIV transmission. Additional risk reduction strategies are provided to meet the needs of all learners, including those who continue to engage in a range of high-risk behaviors. Does not directly promote or encourage sexual activity or drug use.	
8. Resource quality	*The narration, packaging, sound, acting, and/or visual quality does not detract from the overall utility of the resource.	

* CRITERIA SET BY THE PROGRAM REVIEW PANEL, JANUARY, 1989
* Revised and approved by Panel 04/01.

Resource 6.16

VIDEO Assessment

Title:	**Length:**
Publisher: **Availability:**	**Cost:**
Target Audience:	
Summary and Key Points:	
Strengths/Weaknesses: (appeal, accuracy, approach, completeness, tone, "isms", etc.)	
Use and Student Reaction:	
Other:	

/Cox

Resource 6.17

Website Evaluation Criteria

Authority:

Who is sponsoring the page? (Publisher)
What are the author's qualifications for writing on this subject?
Is health information provided by medically trained and qualified professionals?
Challenges:
- May need to back up through the URL to find sponsoring organization
- Authorship is frequently absent, or author's qualifications are absent

Accuracy:

Are sources of factual information listed so they can be verified (e.g., references)?
Is health information supported by references to source data?
Are there grammatical, spelling or other errors?
Who is responsible for the accuracy of the contents?
Challenges:
- Almost anyone can publish on the Web
- Many Web resources are not verified by editors and/or fact checkers
- Web standards for accuracy are not fully developed

Objectivity:

What is the purpose of the page? (Inform? Explain? Persuade? Entertain?)
If advertising exists, is it clearly differentiated from the informational content?
Challenges:
- Purposes of sponsors often not clear

Currency:

When was the information written?
What is the publication or copyright date?
When was the page last revised?
Challenges:
- Date isn't always included
- Date may have different meanings (e.g., written, placed on Web, last revised)

Design and Access:

Can you get to the site easily?
Is the site clear, well-organized, visually appealing?
Can you navigate within and among documents?
Do the internal links work?

Other Criteria:

Is the site appropriate for the intended audience (e.g., helpful for teachers? developmentally appropriate for young people?)
Can you search for information without providing information about yourself?

Material adapted from: http://www.library.wisc.edu/libraries/Steenbock/bipage/pres/evalweb/titlel.htm , http://weber.u.washington.edu/~libr506/NETEVAL/criteria.html, S.M. Dorman. Health on the Net Foundation: Advocating for Quality Health Information, Journal of School Health; 2002: 72(2), p. 86, and American Public Health Association, "Is your health information reliable?"

/Cox web-site evaluation criteria

7.0 Professional Development

NEED FOR PROFESSIONAL DEVELOPMENT

Teachers and other instructional school staff are the most important resource for an effective HGD program. Because of the importance and sensitivity of the topic, and the potential for controversy surrounding it, staff must be well prepared—in knowledge, comfort, and skill. Not only do skillful teachers most effectively foster learning among their students, but the American School Health Association also reminds us, "A trained teacher who is comfortable with the subject matter is more likely to gain support of parents and less likely to breach any state or school policies."

In addition to content knowledge and a repertoire of effective instructional strategies, teachers of HGD must also possess the following qualifications:

- Belief in the importance and value of HGD instruction.
- Ability to foster a safe classroom environment for all students in which a range of ideas and values can be expressed.
- Relaxed style and non-judgmental attitude that encourages communication.
- Ability and comfort to answer students' questions clearly and accurately, given the bounds established by the HGD advisory board and district.
- Knowledge, comfort, and skill in using a range of instructional strategies to foster skill development among students.

Unfortunately, many elementary school teachers and some secondary level teachers have not received pre-service preparation to teach HGD. According to a national survey of colleges and universities that provide undergraduate preparation of teachers, only 14% of the programs require health education courses for all pre-service teachers and none require a sexuality course (Rodriguez et al, 1995/1996). On a national level, fewer than 10% of health education teachers have received staff development on sexuality issues such as pregnancy prevention (CDC, 1996).

Recent data from the Wisconsin School Health Profile survey indicates that approximately one third of middle and high school teachers with instructional responsibility in these areas received in-service or staff development on human growth and development, HIV, or human sexuality in the past two years (Wisconsin DPI, 2005). About one in four teachers received staff development on pregnancy prevention or STD prevention in the previous two years. More than half of the respondents indicated they would like to receive additional training on growth and development, HIV, human sexuality, pregnancy prevention, and STD prevention. The other topics for which teachers expressed strong interest in additional staff development included violence prevention, suicide prevention, nutrition, emotional and mental health, and alcohol or other drug use prevention—and almost all of these topics are related in some way to human sexuality. The survey also assessed teachers' interest in receiving staff development on teaching methods. Well over half of the middle and high school teachers expressed a desire for additional training focusing on how to teach behavior change

skills. More than 70% indicated they would like more training on teaching communication and decision-making, 63% indicated they would like to learn more about how to encourage family or community involvement and 59% of respondents indicated they would like to learn more about using interactive teaching methods such as role plays or cooperative group activities.

Clearly, there is a need for on-going professional development opportunities for teachers and other school staff providing HGD instruction. It is important to complement teachers' interest in enhancing their knowledge and skills related to teaching HGD with a commitment from school administrators, HGD advisory board, and the school board to make professional development opportunities possible. Opportunities for a multidisciplinary team to engage in professional development related to the HGD program, including planning time, can be particularly important for a comprehensive K-12 HGD curriculum.

RESOURCES FOR HGD TEACHERS AND OTHER PROFESSIONALS

Barbara Huberman. ***Resource Guide for Sex Educations. Basic Resources that Every Sex Educator Needs to Know About***. Advocates for Youth. (2002). Available at **www.advocatesforyouth.org**

SIECUS**. *Guidelines for Comprehensive Sexuality Education: Kindergarten – 12th Grade, Third Edition*. (**2004).
A national model for comprehensive sexuality education with developmental messages for early childhood, preadolescence, early adolescence, and adolescence. Available at **www.siecus.org**

American School Health Association. ***Sexuality Education Within Comprehensive School Health Education. 2nd Edition***. American School Health Association Kent, Ohio (2003).

SIECUS. **SHOP Talk (School Health Opportunities and Progress).**
A bi-weekly publication focusing on school health issues around the country. Available at **www.siecus.org**

ETR: **Resource Center for Adolescent Pregnancy Prevention (ReCAPP)**
ReCAPP provides practical tools and information to effectively reduce sexual risk-taking behaviors. Teachers and Health Educators will find up-to-date, evaluated programming materials to help with their work with teens. **www.etr.org/recapp.htm**

PROFESSIONAL DEVELOPMENT OPPORTUNITIES RELATED TO HGD

The Wisconsin Department of Public Instruction, Student Services/Prevention and Wellness team regularly offers professional development opportunities, such as:

- **Adolescent Sexual Risk Behavior Prevention Institute** at Alverno College, Milwaukee, in the Summer. The institute is for health teachers, school nurses, youth service providers and others who work with youth to reduce risky sexual behaviors. **www.dpi.wi.gov/sspw/asbpi.**html. Contact Linda Carey at 608 267-9354 or linda.carey@dpi.state.wi.us for information.

- **The Power of Teaching.** This is a multiple day workshop for teacher leaders to focus on ways to effectively teach health and safety issues. Based on the DPI publication, *The Power of Teaching*, the workshop covers best practices in curriculum, instruction and assessment. Contact Jon Hisgen at 608-267-9234 or jon hisgen@dpi.state.wi.us for information.

- **Alcohol, Sex and Other Risky Behaviors: Prevention for K-12 Educators** is a week-long summer workshop offered through the Wisconsin Teacher Enhancement Program at the University of Wisconsin-Madison. The class addresses adolescent sexual behavior and other related risk factors by exploring such topics as: national and state data regarding HIV, STIs and teen pregnancy; influences on risky sexual behavior; international differences in sexual health approaches; sexual assault; and STI transmission. Participants address effective prevention and intervention strategies for schools by exploring evidence-based curricula, characteristics of effective prevention programming and designing activities that promote critical thinking among youth. Contact Jon Hisgen at 608-267-9234 or jon hisgen@dpi.state.wi.us for information

For other related training events sponsored by DPI please see:

- **www.dpi.wi.gov/sspw/index.html** and click on the Calendar of Events link.

For related training events sponsored by the Wisconsin Department of Health and Family Services (DHFS) please see:

- Wisconsin Abstinence Initiative for Youth at **www.dhfs.wisconsin.gov/teenpregnancy/index.htm**

- Wisconsin AIDS/HIV Program **www.dhfs.wi.gov/aids-hiv/index.htm** and click on a calendar for a list of upcoming meetings and conferences.

- Wisconsin HIV Prevention Training System **www.wihivpts.wisc.edu** for a calendar of upcoming conferences and training events focused on HIV/AIDS prevention.

References:

American School Health Association.. *Sexuality Education Within Comprehensive School Health Education. 2nd Edition*. American School Health Association Kent, Ohio (2003).

Centers for Disease Control and Prevention. (1996). School-based HIV-prevention education – United States, 1994. *MMWR*; 45:760-765.

M. Rodriguez, R. Young, S. Renfro, M. Ascencio & D.W. Haffner. Teaching our teachers to teach: A SIECUS study on training and preparation for HIV/AIDS prevention and sexuality education. *SIECUS Report*. Vol. 28, No. 2.
(December 1995/January 1996)

Wisconsin Department of Public Instruction. *2004 Wisconsin School Health Education Profile*. (2005) Available on-line.

8.0 Resources

STATE AGENCIES

Wisconsin state agencies and staff who can provide technical assistance on HGD issues:

Wisconsin Department of Public Instruction

Student Services/Prevention and Wellness Team
PO Box 7841
Madison, WI 53707-7841
www.dpi.wi.gov/sspw/index.html

Jon Hisgen
Health Education and Physical Activity Consultant
608-267-9234
jon.hisgen@dpi.state.wi.us

Emily Holder
HIV/AIDS/STD Prevention Consultant
608-267-9170
emily.holder@dpi.state.wi.us

Sharon Strom
Family and Consumer Education Consultant
608-267-9088
sharon.strom@dpi.state.wi.us

Brian Weaver
Comprehensive School Health Programs Consultant
608-266-7921
brian.weaver@dpi.state.wi.us

Wisconsin Department of Health and Family Services

Division of Public Health
1 West Wilson Street
Madison, Wisconsin
www.dhfs.wi.gov

Claude Gilmore
Comprehensive School Health Program and Youth Policy Director
608-266-9354
gilmoca@dhfs.state.wi.us

Wisconsin Department of Health and Family Services (continued)

Division of Public Health
Norma Denbrook
Abstinence Program Coordinator
608-261-7654
denbrn@dhfs.state.wi.us
www.dhfs.wisconsin.gov/waiy/index.htm

Karen M. Johnson
HIV Prevention Consultant
608/266-1808
johnskm@dhfs.state.wi.us
www.dhfs.wisconsin.gov/aids-hiv/

Wisconsin Sexually Transmitted Diseases (STD) Program
www.dhfs.wi.gov/communicable/STD/staff.htm

FEDERAL AGENCIES

National Institutes of Health, National Library of Medicine. Medline Plus: Teenage Pregnancy. This informational website has links to the latest news, research, publications, data and research articles relating to teenage pregnancy.
www.nlm.nih.gov/medlineplus/teenagepregnancy.html

CDC, National Center for HIV, STD and TB Prevention, DHAP. This division is responsible for the CDC's HIV/AIDS prevention efforts in the United States. This website contains basic science, surveillance, prevention research, vaccine, prevention tools, treatment, funding, testing, evaluation , and training information about HIV, sexually transmitted diseases (STDs), and tuberculosis.
www.cdc.gov/hiv/dhap.htm

CDC, National Prevention Information Network (NPIN). This section of CDC provides information about HIV/AIDS, STDs, and tuberculosis to people and organizations working in prevention, health care, research, and support services. The website contains information, facts, databases, services, and publications about HIV/AIDS, STDs, and tuberculosis. The CDC MMWRs are also available through NPIN.
www.cdcnpin.org

DHHS, Office of the Surgeon General. Of particular importance for sexuality education is The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior.
www.surgeongeneral.gov/library/sexualhealth/default.htm

CDC, Division of Adolescent and School Health (DASH). This division seeks to prevent the most serious health risk behaviors among children, adolescents and young adults. The website contains important information about adolescent health issues and links to related information.
www.cdc.gov/HealthyYouth/index.htm

SELECTED NATIONAL ORGANIZATIONS

Advocates for Youth. Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their reproductive and sexual health. Advocates provide information, training, and strategic assistance to youth-serving organizations, policy makers, youth activists, and the media in the United States and the developing world.
www.advocatesforyouth.org

Henry J. Kaiser Family Foundation. The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. This organization addresses numerous health issues, including adolescent sexuality.
www.kff.org/youthhivstds/index.cfm

Sexuality Information and Education Council of the U.S. (SIECUS). SIECUS is a national nonprofit organization which affirms that sexuality is a natural and healthy part of living. It develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates for the right of individuals to make responsible sexual choices.
www.siecus.org

National Association of State Boards of Education Safe and Healthy Schools Projects aims to help policymakers and practitioners create safe, healthy, and nurturing school environments for all of the nation's children and youth.
www.nasbe.org/HealthySchools/index.mgi

National School Boards Association School Health Programs commitment to help school policymakers and educators make informed decisions about health issues affecting the academic achievement and healthy development of students and the effective operation of schools.
www.nsba.org/site/page_SH_home.asp?TRACKID=&VID=62&CID=1113&DID=12019

Council of Chief State School Officers School Health Project was founded in 1987 to build the capacity of chief state school officers, their staff, and partners to create strong school health policies and programs that support the goal of removing the nonacademic barriers to learning faced by the nation’s children.
www.ccsso.org/projects/School_Health_Project/